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FOCUS on Health Reform

THE HENRY J. KAISER FAMILY FOUNDATION

APRIL 2013

Consumer Assistance in Health Reform

The Affordable Care Act (ACA) establishes new requirements and resources for consumer assistance in order to help people navigate the changing health coverage system, find affordable coverage, determine eligibility for assistance, appeal denied claims and program eligibility determinations, resolve problems, and answer questions related to their health coverage.

Experience underscores need for consumer assistance. For years, millions of Americans have been estimated to be eligible for but not enrolled in public programs such as Medicaid and CHIP.[1] Studies of health insurance literacy document that consumers do not understand their health insurance coverage – including benefit limits and exclusions, network designs, and cost sharing features – or, when they have coverage choices, how to evaluate options.[2] And, when claims are denied or other coverage problems arise, many consumers find it difficult to resolve problems on their own and don't know where to turn for help.

The ACA seeks to expand coverage and to promote competition among health insurers in order to control costs. Achieving these goals depends on consumers' ability to actively and effectively participate in health coverage in ways they do not today. This brief outlines the needs for consumer assistance that people will have and the resources available under the ACA to address them, and identifies implementation issues that may impact the effectiveness of consumer assistance.

The need for consumer assistance

The job of consumer assistance will not be limited to a single task. Rather, as consumers seek to get and keep health coverage, they may face a series of challenges that assisters will need to address.

Increasing public education and awareness – Surveys continue to find that many Americans lack a basic understanding of the new plan options and financial assistance that will become available in 2014. A recent Kaiser Family Foundation poll showed that two-thirds of the uninsured and a majority of Americans overall say they have too little information to know how the Affordable Care Act will affect them.[3] A necessary first task for consumer assistance will be to inform the public about individuals' responsibility to enroll in qualified coverage, new coverage options and subsidies, and where to go for more help.

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[1] See for example "The State of Children's Health, Care and Coverage," April 4, 2011, at http://www.kff.org/ahr040411video.cfm

[2] Quincy, L and Child, W, "Health Insurance Literacy: A Call to Action," February 2012. Available at http://www.consumersunion.org/pub/Health_Insurance_Literacy_Roundtable_rpt.pdf

[3] Kaiser Family Foundation, March 2013 Tracking Poll. Available at http://www.kff.org/kaiserpolls/8425.cfm

Determining eligibility for assistance – Two main types of insurance affordability programs (IAP) will be available beginning in 2014 – expanded Medicaid coverage and subsidized private non-group health insurance coverage through Exchanges.

The ACA expands and simplifies eligibility for Medicaid so that all adults with income up to 138% of the federal poverty level (FPL) can gain coverage under the program.[4] States have the option of electing this expansion and some have indicated they will not do so, at least initially.

In addition, new private health insurance coverage options will be offered along with financial help to make coverage affordable. Advance-payment premium tax credit (APTC) subsidies – available on a sliding scale to those with income between 100% and 400% of FPL– will reduce the monthly premium people pay for non-group coverage.[5] To be eligible for APTC, people also must be ineligible for other sources of health coverage – Medicaid, Medicare and other specified public programs, or employer-sponsored group health plan coverage that meets minimum standards. Cost sharing reduction (CSR) subsidies will also be available on a sliding scale for people with income between 100% and 250% FPL.

Consumers can apply for IAP through state Exchanges, and Exchanges are required to make it as simple as possible for consumers to determine eligibility and enroll in the correct assistance program. Exchanges must use a single streamlined application for all IAPs and provide for online application and enrollment. Even so, many consumers are likely to need additional help. One state, for example, estimates that between 20 and 25 percent of people who enroll in new coverage in 2014 will need consumer assistance.[6] Consumers might seek assistance when they aren't familiar with new coverage programs or if they find health insurance confusing. Language assistance will be important to an estimated 9 percent of nonelderly adults who have limited English proficiency. Other people might need help sorting out more complex personal circumstances, such as when family members have mixed eligibility status for Medicaid, or when job-based coverage is available to some, but not all, family members. When disputes arise over eligibility for assistance – either at initial enrollment or at renewal – consumers may also need help appealing eligibility decisions.[7]

Enrolling in coverage – For newly insured individuals who enroll in non-group coverage, a choice of plans and coverage levels will be available. Multiple insurers are expected to offer policies in every Exchange and new plan options – health insurance co-ops and multi-state health plans – will also be offered. Consumers will need to compare plan options in order to make an informed enrollment decision. Traditionally, consumers have had difficulty understanding and evaluating options due to the complexity of products and programs, health insurance literacy barriers, and other factors. Starting in 2014, plan

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[4] Medicaid eligibility restrictions for non-citizens will remain unchanged.
[5] This means individuals with incomes between approximately $11,500 and $46,000 would be eligible for premium subsidies; for a family of 4, subsidies would apply for income of $23,550 to $94,200.
[6] Washington Health Benefit Exchange: Proposed Navigator Program, January 2013. Available at http://wahbexchange.org/wp-content/uploads/HBE_130111_Navigator_Program_Plan_Draft.pdf
[7] The appeals systems will also vary depending on the nature of the dispute. Different processes will apply for disputes over Medicaid eligibility, eligibility to participate in the Exchange, and disputes over year-end reconciliation of taxes owed. See Salganic S, et al, "Making the Affordable Care Act Work for New York's Consumers," October 2012. Available at http://b.3cdn.net/nycss/dc35662a7590c21108_9um6befdp.pdf

comparison will be quite a bit easier. Private health insurance policies will become more standardized and new, easier-to-read plan summaries also must be available.[8] However, significant plan differences will persist:

- All non-group policies will cover essential health benefits, though insurers will have some flexibility to vary covered benefits within limits.[9]
- All policies will also be offered with different cost sharing options – labeled as bronze, silver, gold, and platinum. But, insurers will have flexibility to vary the specifics of cost sharing within these "metal tiers" as well, within limits.[10]
- Other plan features, such as provider networks and drug formularies, can also vary.

Before enrolling, consumers also might seek help evaluating plan choices, taking into account the subsidies for which they are eligible. Most people who buy non-group coverage through the Exchange are expected to be eligible for subsidies.[11] Premium tax credit subsidies will be based on the cost of the second lowest cost silver plan offered in an Exchange, but people can use the APTC subsidy to purchase any policy offered in the Exchange. Cost sharing subsidies, however, can only be applied to silver plans.

Assisting with questions and coverage problems – All consumers – not just those who will be covered in the Exchange – may experience difficulty using insurance once they've enrolled. Consumers tend to find health insurance confusing, and often have difficulty resolving problems and questions on their own. For example, a 2009 Kaiser Family Foundation national survey of consumer experiences with health plans found that 26% of privately insured adults reported their plan wouldn't pay for care they thought was covered. Of these individuals only 9 percent eventually got insurance to pay for the treatment, while 40 percent went without treatment or paid out of pocket for care.[12] Especially when people are sick, managing insurance problems can be a challenge and many give up. Another survey found that even when problems generated out-of-pocket costs to the patient of more than $1,000 or led to a serious decline in health, fewer than 40 percent of individuals complained to their health plan, and only rarely (3%) did they file complaints with state regulators.[13] Unresolved insurance problems can result in medical debt and/or difficulty accessing care. Consumers report they want and need help, but many don't know where to turn. In another KFF survey, 89% of consumers didn't know the agency that

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[8] Kaiser Family Foundation, "Uniform Coverage Summaries for Consumers," October 2011. Available at http://www.kff.org/healthreform/upload/8244.pdf

[9] States are permitted to limit variation in covered plan benefits. See Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Final Rule. February 25, 2013. Available at http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf

[10] States are permitted to limit variation in plan cost sharing design. See Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Final Rule. February 25, 2013. Available at http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf

[11] Congressional Budget Office, "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision, July 24, 2012. Available at http://cbo.gov/publication/43472

[12] NPR/Kaiser Family Foundation/Harvard School of Public Health, "The Public and the Health Care Delivery System," April 2009, available at http://www.kff.org/kaiserpolls/posr042209pkg.cfm

[13] Brian Elbel and Mark Schlesinger, "Responsive Consumerism: Empowerment in Markets for Health Plans," *The Millbank Quarterly,* Vol. 87, No. 3, 2009.

regulates health insurance in their state; 84% wanted an independent entity where they could seek help.[14]

Navigating mid-year changes – Income fluctuation, employment changes, or changes in family or immigration status may also change eligibility for IAPs for many individuals. One study estimates that as many as 50 percent of low income adults might experience income or other changes that would shift their eligibility from Medicaid to Exchange coverage (or the reverse) at least once within a year.[15] People will be required to report mid-year eligibility changes, and may be offered opportunities to enroll in new coverage or assistance for which they become eligible. However, consumers will first need to recognize changes – for example, when a baby is born a family's eligibility for assistance can change, even if income remains steady, because poverty thresholds change with household size – and know to act on them promptly. Otherwise they might lose the opportunity to enroll in new coverage. In addition, in the case of some mid-year changes that would reduce the amount of APTC subsidy to which a person is entitled in a year, failure to report changes could result in people having to repay through their income tax returns some or all of APTCs that were appropriate when they first enrolled but that no longer apply. This could cause financial burdens for some individuals or discourage them from applying for assistance.

Mid-year changes in enrollment might also result from failure to pay premiums on time. Under the ACA, APTC assistance constitutes a partial subsidy. Individuals remain responsible for paying a portion of the premium; even the poorest individuals would be required to pay approximately $20 per month for self-only coverage.[16] Consumers may need help resolving disputes over missed or late payments. People dis-enrolled for non-payment might require help finding new coverage options.

Sources of consumer assistance

The ACA and its implementing regulations provide for multiple sources of consumer assistance. Programs vary to some extent by the populations served; the nature of assistance provided; qualifications and other requirements pertaining to the providers of consumer assistance; and in the sources, timing, and amount of funding available for each program.

Statewide Consumer Assistance Programs (CAPs)

Section 1002 of the Affordable Care Act established a program of State Consumer Assistance Programs or ombudsman programs (CAPs) funded by federal grants to states.[17] Federally-funded state CAPs were first established in 2010. Most are still in place today, although some operate at reduced levels due to funding uncertainty.

[14] Kaiser Family Foundation, "National Survey of Consumer Experiences with Health Plans," June 2000.
[15] Sommers B and Rosenbaum S, "Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges," *Health Affairs*, February 2011.
[16] See http://healthreform.kff.org/Home/KHS/SubsidyCalculator.aspx?source=FS
[17] CAP provisions of the ACA are written into Section 2793 of the Public Health Service Act.

Consumer assistance duties - To be eligible to receive a grant, States must establish and carry out programs that provide a full range of consumer assistance services and activities. Five main duties required of CAPs are to:

- assist consumers with filing complaints and appeals, including appeals of denied claims and other adverse determinations by health insurers and group health plans;
- collect, track, and quantify problems and inquiries encountered by consumers;
- educate consumers on their rights and responsibilities with respect to group health plan and health insurance coverage;
- help consumers with enrollment in private health insurance or group health plan coverage;
- resolve problems obtaining health insurance subsidies (APTCs).

CAPs are also required to "advocate freely and vigorously" on behalf of consumers.[18] Typically, CAP assistance involves casework that tends to be more hands-on and resource-intensive compared to, for example, call centers that provide brief informational responses to consumer questions. Consumers who seek help from CAPs may have multiple contacts with the program over a period of time as CAP staff work with a health plan or regulator to diagnose a problem and resolve it.

Qualifications and training – A CAP grant recipients must be a state agency or entity. Most CAP programs are housed in state Insurance Departments or Health Departments or offices of the state Attorney General. In two states, the CAP is located in a freestanding Consumer Ombudsman agency. States are permitted to partner with non-profit organizations to provide assistance services in local communities and half of CAPs do so. The federal government provides a dedicated staff team within the Center for Consumer Information and Insurance Oversight (CCIIO) to support the CAPs, providing software, information resources, and ongoing training and technical assistance. Regular conference calls with CAP grantees also offer programs an opportunity to share information and learn from each other. It is common for CAP workers to "pick up the phone at any time and call any of the other programs."[19]

Population served - CAPs are required to serve all residents of a state, although specified duties generally relate to assistance enrolling in or resolving problems with private health insurance and group health plans. People covered in self-insured employer sponsored group health plans can and do call on CAPs for assistance; though federal law still preempts states from regulating such plans, the CAP program effectively empowers states to help enrollees of such plans by advocating on their behalf to help resolve problems such as denied claims. CAPs also are allowed – but not required – to use grant funds to assist individuals with enrollment and problem resolution in public programs, such as Medicaid or the Pre-existing Condition Insurance Program (PCIP). If CAPs decide not to provide assistance to public program enrollees, they must at least make appropriate referrals to Medicaid or other applicable agencies. Beyond merely giving a consumer the name and phone number of another agency, CAP

[18] Affordable Care Act – Consumer Assistance Program Grants. Funding Opportunity Number: CA-CAP-12-002, CFDA: 93.519, June 7, 2012.

[19] Grob R, et al., "The Affordable Care Act's Plan For Consumer Assistance with Insurance Moves States Forward But Remains A Work in Progress," *Health Affairs*¸ February 2013.

personnel in many states will call the agency on the consumer's behalf, and even remain involved in the case, collaborating with the other agency, until the problem is resolved.[20] This referral is sometimes described as a "warm handoff." Finally, CAPs must meet standards for accessibility, and provide assistance that is culturally and linguistically appropriate.

Sentinel Function - The ACA mandates that CAPs track consumer problems and inquiries and report data to the Secretary of Health and Human Services (HHS.) In turn, HHS is required to analyze data to identify areas where more enforcement is needed and share this information with state insurance regulators and the Departments of Labor and Treasury. HHS has released one report summarizing the first year of CAP data.[21] In the first year, as many programs were getting started, CAPs provided assistance to more than 200,000 consumers, including helping to appeal almost 26,000 denied claims and recover more than $18 million in covered benefits. CAPs also received more than 3,000 inquiries about new ACA protections, such as the requirement to continue dependent coverage to age 26 and the prohibition on health insurance rescissions. Through data and their familiarity with the details of consumer problems, CAPs are in a position to identify opportunities to strengthen consumer protection such as through improved notice requirements and better coordination of regulatory agencies. To date, however, data collection and reporting by CAPs has been somewhat inconsistent and this sentinel function remains a work in progress.[22]

Funding – The ACA permanently authorized "such sums as may be necessary" to support CAPs and made an initial appropriation of $30 million for the program. The first federal CAP grants were issued in September 2010, establishing 38 programs in 33 States and the District of Columbia. A second round of $30 million in CAP grants was awarded in August 2012 to 21 states and DC. To date, 36 States and DC have established CAP programs using federal grant funds.[23] States also can use and have used funds from Exchange establishment grants, authorized under Section 1311 of the ACA, to support some CAP activities that are directly related to the planning and implementation of an Exchange.[24]

Funding limitations and uncertainty have resulted in uneven implementation of CAP assistance across states.[25] Under the ACA there is no fallback authority for the federal government to establish CAPs in states that do not.

[20] Grob R, et al.

[21] "Summary of Consumer Assistance Program Grant Data from October 15, 2010 through October 14, 2011, June 7, 2012, available at http://cciio.cms.gov/resources/files/csg-cap-summary-white-paper.pdf.pdf

[22] Grob R, et al.

[23] Two other states, Ohio and Wisconsin, also received CAP grants in 2010 but returned funds shortly after the November elections. US Territories are also eligible to receive CAP grants; 4 Territories received grants in 2010 and 2 received grants in 2012. For more detail on CAP grant recipients and awards see http://statehealthfacts.kff.org/comparereport.jsp?rep=88&cat=17

[24] States may not use 1311 grant funds to support the entire functionality of their CAP programs, but can use funds for activities that also relate to Exchange functions, such as conducting outreach and developing training programs. See "State Consumer Assistance Program Participation in Exchange Core Area 10", November 21, 2011. Available at http://cciio.cms.gov/resources/files/Files2/11172011/cap_exchange_funding_memo.pdf.pdf

[25] Grob R, et al.

Exchange Programs of Consumer Assistance

Consumer assistance is also a core function of health insurance Exchanges. Assistance required in Exchanges focuses primarily on outreach, eligibility and enrollment. All Exchanges are required to provide a website that displays consumer information about available plans and financial assistance, including a subsidy calculator, and that enables people to submit an electronic application for assistance and to enroll online in a QHP. Exchanges must also operate a toll-free call center to provide information and respond to requests for assistance. In addition, under the ACA and its implementing regulations and other guidance, several programs of direct consumer assistance are authorized to be offered through Exchanges: Navigators, In-Person Assistance Programs, and Certified Application Counselors. Navigators and Certified Application Counselors are required for all Exchanges. In-Person Assistance Programs may or may not be offered depending on whether an Exchange is state based, federally facilitated, or a partnership Exchange. The duties, qualifications, populations served and funding sources for these programs vary by program, as well as by who (States or the federal government) runs the Exchange.

Navigator programs are required by statute, while regulations and other federal guidance outline requirements and standards regarding In-Person Assistance programs and Certified Application Counselors. These other types of "non-Navigator" assisters can be used to fill gaps in or supplement the work of Navigators programs. In addition, the source and timing of funding for non-Navigators are different than for Navigators; as a result states may establish multiple programs in order to maximize resources available for consumer assistance.

Navigators

The ACA requires all Exchanges to establish a Navigator program to help consumers learn about qualified health plan coverage and subsidies offered through Exchanges and enroll in such coverage. As a required component of Exchanges, Navigator programs must be established starting in 2014, although recent federal guidance acknowledges that Navigator programs might not be fully functional in every state in 2014 and expressly permits States to use non-Navigator consumer assistance programs to fill in any gaps during the initial year.[26]

The structure of and responsibility for Navigator programs will vary somewhat depending on the decision states make regarding the operation of health insurance Exchanges. States will establish, operate, train, oversee and fund Navigator programs in state-based Exchanges (SBEs). The federal government will do so in federally-facilitated Exchanges (FFEs). In state partnership Exchanges (SPEs) where the state elects to take on a consumer assistance role, the federal government will establish and

[26] Patient Protection and Affordable Care Act: Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel. Proposed rule. April 5, 2013. Available at http://www.gpo.gov/fdsys/pkg/FR-2013-04-05/pdf/2013-07951.pdf

fund the Navigator program and provide training, while States will be responsible for the day-to-day operation of Navigator programs and can supplement training.

Consumer assistance duties – In all states, entities that serve as Navigators will be required to:

- conduct public education activities to raise awareness about the Exchange and maintain expertise in eligibility, enrollment, and program standards under the Exchange;
- provide accurate and impartial information concerning private health insurance plans offered through the Exchange – called qualified health plans or QHPs – and about premium and cost sharing subsidies available for such plans; this information must also acknowledge other health programs;
- provide fair and impartial help to people in selecting a QHP;
- provide referrals to state CAPs or other appropriate state agencies that can help people with other grievances, complaints or questions regarding their health coverage; and
- provide information and assistance in a manner that is culturally and linguistically appropriate and accessible by persons with disabilities.

Qualifications and training – In all states, the Exchange must designate at least one community and consumer-focused nonprofit group as a Navigator. In addition, the Exchange must designate at least one other type of Navigator from a list of specified categories.[27] Health insurance issuers, including their subsidiaries and associations, are prohibited from being Navigators. So is any person or entity that receives any direct or indirect consideration from a health insurance issuer in connection with the enrollment of people in a private health insurance plan, whether offered in or outside of an Exchange (e.g., insurance agents paid commissions by insurers). Navigators must meet applicable licensing, certification or other standards prescribed by the state or Exchange. Conflict-of-interest standards also apply and Navigators will be required to submit to the Exchange a written plan for remaining conflict-free while serving in this capacity. Navigators also must comply with privacy and security standards adopted by the Exchange.

Navigators must have or develop relationships with individuals or employers likely to be eligible to enroll in QHP coverage through the Exchange. Finally, Navigators must undergo training to ensure expertise in the needs of underserved and vulnerable populations, eligibility and enrollment rules and procedures, the range of QHP options and IAPs offered through an Exchange, and privacy and security standards for personal information. Federal Navigator training will take up to 30 hours and certification will require a passing score on HHS-approved examinations. States may use the federal training program or develop their own Navigator training programs.

Population served – In general Navigators must target information and assistance to individuals and employers who seek private health plan coverage offered in the Exchange. However, states can require

[27] 45 CFR §155.210. These categories are (1) trade, industry, and professional associations; (2) commercial fishing industry organizations, ranching and farming organizations; (3) chambers of commerce; (4) unions; (5) resource partners of the Small Business Administration; (6) licensed agents and brokers, and (7) other public or private entities or individuals that meet the requirements for Navigators including, but not limited to, Indian tribes and tribal organizations and State or local human service agencies.

Navigators to also help individuals apply for and enroll in Medicaid, and some have elected to do so.[28] The range of types of eligible entities enumerated in the ACA indicates that states can establish Navigator programs that are locally focused and specialize in providing assistance to targeted groups or communities. In state partnership Exchanges, for example, HHS has said Navigators may target their outreach and assistance to specific ethnic, geographic, or other communities.[29]

Sentinel function – The ACA does not specify data collection or reporting responsibilities for Navigators. States may choose to require Navigators to track data on consumer inquiries, concerns and problems. To date no federal guidance has specified this role for Navigators in FFEs or SPEs.

Funding – Navigators are funded by grants financed by an Exchange's operating revenue, which will first be generated in 2014 through assessments on health insurers offering coverage within a State. To finance the planning and establishment of Exchanges, states can also receive federal grants through the end of 2014 under Section 1311 of the ACA.[30] States are prohibited from using Section 1311 grants to fund their Navigator grants, but can use them for planning activities related to Navigators, such as the development of training materials or to build and test Navigator programs.[31] In the initial year of operation, states can also use Section 1311 grants to establish (In-Person Assistance programs if their Navigator programs are not yet fully developed. States that elect to use Navigators to provide Medicaid assistance can also fund programs using Medicaid administrative funds.

For the 34 federal and partnership Exchanges combined, HHS will provide $54 million in funding to support Navigator programs in the first year. That amount will be apportioned based on the number of uninsured in a state.[32]

After 2014, states and the federal government will determine the budget for Navigators within overall Exchange operating revenues. There are no requirements to devote a specified portion of Exchange operating revenues for Navigators or other forms of consumer assistance. Specific details of Navigator

[28] See for example, "Options for the Design and Implementation of Maryland's Navigator Program" November 15, 2012, available at http://marylandhbe.com/wp-content/uploads/2013/01/MHBE-Navigator-Report-Final.pdf. See also "Request for Applications, Consumer Assistance for the New York State Health Benefit Exchange: In Person Assistors and Navigators," available at http://www.health.ny.gov/funding/rfa/1301300317/1301300317.pdf.

[29] See "Guidance on the State Partnership Exchange" issued by CCIIO on January 3, 2013. Available at http://cciio.cms.gov/resources/files/partnership-guidance-01-03-2013.pdf

[30] Section 1311 grants are funded by an open-ended federal appropriation through the end of 2014, allowing states to make considerable investments in outreach, planning, IT, systems development and other activities necessary to establish new Exchanges.

[31] Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges. Funding Opportunity Number: IE-HBE-11-004, CFDA: 93.525, January 20, 2011. See also Center for Consumer Information and Insurance Oversight, Guidance on the State Partnership Exchange, January 3, 2013. Available at http://cciio.cms.gov/resources/files/partnership-guidance-01-03-2013.pdf

[32] Apportioned amounts range from $600,000 for Alaska to almost $8.2 million for Texas. See Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Exchanges, CFDA 93.750, April 9, 2013.

compensation will also be determined by the Exchange. Options under consideration include a flat fee payment per successful application and performance-based block grants tied to enrollment targets.[33]

In-Person Assistance Programs

In-Person Assistance (IPA) programs, distinct from Navigators, may also be established within an Exchange, depending on the state. IPA programs are required in state partnership Exchanges where the state elects to take on a consumer assistance role; they are optional in state-based Exchanges, and they will not be offered in federally facilitated Exchanges.[34]

In states operating a partnership Exchange, HHS requires such programs because "some communities may not have entities that apply to be Navigators, while other entities intending to serve specific communities may not be selected to receive a Navigator grant." In states running their own Exchanges, IPA programs are optional and states have flexibility to use IPA programs to expand or strengthen consumer assistance in their Exchanges. State-based Exchanges may also rely more heavily on In-Person Assistance Programs in 2014 if their Navigator programs are not fully functional in that year.

In general, IPA programs are required to ensure that in-person assistance is available to consumers who need it. They are supposed to supplement Navigator programs, not replace them nor duplicate effort. States have broad authority to design IPA programs. For example, IPA programs might operate only during initial and annual open enrollment periods when demand for eligibility and enrollment assistance is highest.[35]

Consumer assistance duties – Specific duties for IPA programs will be determined by the Exchange. For example, the IPA program might help consumers apply for subsidies and enroll in plans, but not engage in general outreach activities.

Qualifications and training – The Exchange will also determine who can serve as an In-Person Assister. States have the option of contracting with CAPs to provide IPA services.[36] Like Navigators, IPA programs must provide information and assistance in a manner that is culturally and linguistically appropriate and accessible by persons with disabilities. Conflict-of-interest standards for Navigators also will apply to

[33] See for example, California Health Benefit Exchange, "Assisters Program: In-Person Assistance and Navigator Stakeholder Webinar," March 14, 2013, available at http://www.healthexchange.ca.gov/StakeHolders/Documents/Assisters2ndWebinar%20March14-2013_FINAL.pdf
[34] Cite January 3 2013 guidance on state partnership Exchange; Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges, November 16, 2012, available at http://cciio.cms.gov/resources/files/hie-blueprint-11162012.pdf; and May 12, 2012 general guidance on FFE.
[35] Center for Consumer Information and Insurance Oversight, Guidance on the State Partnership Exchange, January 3, 2013. Available at http://cciio.cms.gov/resources/files/partnership-guidance-01-03-2013.pdf
[36] Center for Consumer Information and Insurance Oversight, Guidance on the State Partnership Exchange, January 3, 2013. Available at http://cciio.cms.gov/resources/files/partnership-guidance-01-03-2013.pdf

IPAs. Federal training standards and programs for Navigators will also apply to In-Person Assisters, and states will have the option of supplementing training programs.[37]

Sentinel function – States may choose to require IPA programs to track data on consumer inquiries, concerns and problems. To date no federal guidance has specified this role for IPA programs in SPEs.

Funding – States can use Section 1311 grants to set up and fund first year costs for IPA programs. Thereafter programs would need to be funded by Exchange operating funds or other sources.

Certified Application Counselors

Recently CMS proposed that a third program of consumer assistance be available in all Exchanges – Certified Application Counselors (CACs).[38] The proposed rule cites a long tradition of state Medicaid and CHIP agencies working with health care providers and other organizations to serve as application assisters. It proposes that states have the option of designating certain organizations, such as community health centers, and formally certifying their staff and volunteers to act as application assisters. In addition, the proposed rule requires Exchanges to have a program of Certified Application Counselors.

Consumer assistance duties – Medicaid CACs would provide information about Medicaid and CHIP, help individuals complete applications and renewals, gather required documentation, respond to requests from the Medicaid agency, and provide case management between eligibility determinations and renewals. Exchange CACs would provide information on all insurance affordability programs and QHP coverage options and help individuals apply for and enroll in coverage.

Qualifications and training – State Medicaid programs would designate who can act as a Medicaid CAC. The Exchange can also designate organizations to be CACs. In addition, federal regulations would require Exchanges to certify any individual who asks to be a CAC and who registers with the Exchange and completes training. Exchanges would also be required to certify Medicaid-designated CACs. States have the option of creating a single certification process for both types of CACs. Both Medicaid and Exchange CACs must undergo training in eligibility and benefit rules governing enrollment in QHPs and all insurance affordability programs. Both must also be trained in and subject to rules relating to the confidentiality and security of information. The proposed rule estimates training for Medicaid CACs will take an average of 50 hours. Under the proposed rule, Exchange CACs can have – but must disclose to the Exchange and to potential applicants whom they assist – conflicts of interest, including relationships with QHPs. Both types of CACs must provide assistance that is accessible to persons with disabilities.

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[37] Patient Protection and Affordable Care Act: Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel. Proposed rule. April 5, 2013. Available at http://www.gpo.gov/fdsys/pkg/FR-2013-04-05/pdf/2013-07951.pdf

[38] Medicaid, CHIP, and Exchanges: …Other Provisions Related to Eligibility and Enrollment for Exchanges…, Proposed rule, January 22, 2013. Available at http://www.gpo.gov/fdsys/pkg/FR-2013-01-22/pdf/2013-00659.pdf

Medicaid CACs – but not Exchange CACs under the proposed rule – must also provide assistance appropriate to the needs of LEP individuals.

Sentinel function – States may choose to require CACs to track data on consumer inquiries, concerns and problems. To date no federal guidance has specified this role for CACs.

Funding – Under the proposed rule, CACs are volunteers or work for organizations willing to pay them for their assistance services. CACs are not funded by the Exchange through grants or directly. CACs (both Medicaid and Exchange) are also prohibited from charging individuals a fee for assistance.

Comparison of Programs of Consumer Assistance under the ACA

	CAPs	Navigators			IPAs			Medicaid CACs	Exchange CACS
		SBE	SPE*	FFE**	SBE	SPE*	FFE**		
Required?	State option	Yes	Yes	Yes	State option	Yes	No	State option	Yes
Population Served									
• People seeking QHP	Yes	Yes	Yes	Yes	State option	Yes	n/a	State option	Yes
• People seeking Medicaid	State option	State option	State option	No	State option	State option	n/a	Yes	Yes
• Enrollees of private plans, including ESI	Yes	State option or refer to CAPs	State option or refer to CAPs	No Refer to CAPs	State option	State option	n/a	No	No
Duties									
• Education/outreach	Yes	Yes	Yes	Yes	State option	State option	n/a	No	No
• Help with QHP and subsidy application through Exchange	Yes	Yes	Yes	Yes	Yes	Yes	n/a	State option	Yes
• Help with Medicaid enrollment	State option or refer to Medicaid	State option or refer to Medicaid	State option or refer to Medicaid	No Refer to Medicaid	State option	State option or refer to Medicaid	n/a	Yes	State option
• Help with mid-year changes	Yes	Yes	Yes	Yes	State option	State option	n/a	Yes	Yes
• Resolve plan problems, appeal denials	Yes	State option or refer to CAPs	State option or refer to CAPs	No Refer to CAPs	No	No	n/a	No	No
• Data collection and reporting	Yes	State option	State option	To be determined	State option	State option	n/a	State option	To be determined
• LEP standards	Yes	Yes	Yes	Yes	Yes	Yes	n/a	Yes	No
• Accessibility standards	Yes	Yes	Yes	Yes	Yes	Yes	n/a	Yes	Yes
• Privacy and information safeguards apply	Yes	Yes	Yes	Yes	Yes	Yes	n/a	Yes	Yes
Training	HHS	State	HHS ***	HHS	State	HHS	n/a	Medicaid	HHS ****
Funding	Fed grants to states; $60 million so far	Grants from Exchanges; amount determined by Exchange	Fed grants ($54 million) in year 1, then grants from Exchanges; amount determined by Exchange		§1311 grants in year 1 (States request amount); then funded by Exchange, amount determined by Exchange		n/a	n/a	n/a

* State-based Consumer Assistance Partnership Exchanges

** Federally Facilitated Exchanges and SBEs that do not elect a consumer assistance role

***State option to supplement federal training

The Role of Insurance Brokers and Agents

Private health insurance traditionally has been sold through brokers and agents (described herein as brokers) who receive a commission for each new policy or renewal. Brokers are expected to continue to sell private health insurance outside of Exchanges. In addition, ACA regulations specify that Exchanges may permit agents and brokers to enroll individuals and employers in QHPs sold through the Exchange and brokers may continue to receive commissions as compensation for such sales if they meet other requirements. In particular, they must register with the Exchange, complete training on insurance affordability programs and QHPs, and comply with privacy and security standards. In addition, they must ensure that consumers complete an eligibility verification and enrollment application through the Exchange web site. Brokers can use their own web site to display plan choices, but their site must display all QHP data that the Exchange site displays and their site cannot provide financial incentives to select any plan. In addition, brokers can help individuals apply for subsidies and other insurance affordability programs.[39]

Alternatively, brokers can apply to serve as Navigators. However to qualify as Navigators they must not earn commissions for the sale of health insurance in any market in or outside of the Exchange.

In a number of states, legislation would restrict the role of Navigators and other assisters in relation to brokers. In Maryland for example, Navigators, upon contact with an individual who acknowledges having existing health insurance coverage obtained through a broker, must refer the individual back to the broker for information and service.[40] In several other states, legislation would prohibit Navigators from engaging in any activities that require a broker license. Other state legislation would require Navigators to obtain surety bonds for protection against wrongful acts, errors and omissions, or to meet other requirements that apply to licensed brokers.[41] Recent proposed federal regulations emphasize that any state licensing, certification or other standards for Navigators that prevent the application of ACA Navigator provisions are preempted. The proposed rule offers as one example state requirements that Navigators obtain errors and omissions coverage, but does not otherwise elaborate on the types of state standards that might prevent the application of ACA's Navigator program requirements.[42]

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[39] 45 CFR § 155.220

[40] See MD INS 31-113(f)(8). Exceptions to this rule include when the individual prefers not to be referred back to the broker, when the broker is not authorized to sell QHPs in the Exchange, and when the individual is eligible for subsidies but has not obtained them. Legislation in other states (e.g., HB 564 in New Mexico, HB 2608 in Illinois) would impose the same requirement for Navigators to refer consumers to brokers, but without these exceptions.

[41] Georgetown University Center on Health Insurance Reforms, "Pending Legislation on Navigators in the 50 States and DC," available at http://chirblog.org/wp-content/uploads/2013/03/Gtown_CHIR_NavigatorLegislation1.pdf

[42] Patient Protection and Affordable Care Act: Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel. Proposed rule. April 5, 2013. Available at http://www.gpo.gov/fdsys/pkg/FR-2013-04-05/pdf/2013-07951.pdf

How Will It All Work?

Key implementation details, which will need to be worked out in each state, will determine how effective consumer assistance programs will be. A number of factors will be important to consider as implementation moves forward.

Funding

Resources available for consumer assistance are likely to be uneven across states, at least during the first year. In general, state-based Exchanges have had the opportunity to draw down considerable federal grant resources to plan and build new consumer assistance capacity. Partnership Exchanges that elect a consumer assistance partnership will also have access to substantial federal grant funds to build their new programs. By contrast, states where a federally-facilitated Exchange is operating will have more limited resources, at least until the Exchanges are established and new operating revenues become available.

Many states are still working out their budgets for consumer assistance for 2013-2014. New York, for example, intends to make $27 million per year available for Navigator and In-Person Assistance funding over each of the next five years.[43] New York's CAP estimates the cost of consumer assistance at $90 per case, on average, reflecting a wide range of problem types (such as complex health claims denial cases addressed under the CAP program and more straightforward eligibility and enrollment assistance cases.)[44] California will make up to $43 million in grants available to nonprofit organizations and other entities to serve as Navigators, budgeting for a payment of $58 per successful enrollment in the first year.[45] In Texas, by contrast, federal Navigator funding is anticipated to be just over $8 million for the first year.[46]

Early experience with CAPs shows that limited and uncertain funding can hamper the continuity and effectiveness of assistance programs. Once Exchanges and their operating budgets are established, states and the federal government will need to decide on a level of resources to devote toward consumer assistance over time.

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[43] NY State Department of Health, Request for Applications, Consumer Assistance for the NY State Health Benefit Exchange: In Person Assistors and Navigators. Available at http://www.health.ny.gov/funding/rfa/1301300317/1301300317.pdf

[44] Community Health Advocates 2012 Annual Report. Available at http://communityhealthadvocates.org/sites/communityhealthadvocates.org/files/publications/%5Bsite-date-yyyy%5D/CHA%202012%20Annual%20Report_0.pdf

[45] California Health Benefit Exchange, Outreach and Education Grant Application. Available at http://www.healthexchange.ca.gov/Pages/OutrchandEdProg.aspx

[46] Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Exchanges, CFDA 93.750, April 9, 2013.

Organization and coordination of assisters

Beyond the dollar resources, effectiveness of consumer assistance will also depend on how states organize and coordinate their programs. Ideally, consumers would be able to find all the assistance they need in one place or through one phone call. In New York, for example, Community Health Advocates (CHA) runs a central toll free hotline and contracts with a network of 30 nonprofit organizations that receive grants and contracts to provide a full range of consumer assistance to individuals with all types of health coverage and the uninsured. CHA staff can help consumers apply for Medicaid or Exchange subsidies, appeal eligibility determinations, enroll in coverage, and resolve disputes with health plans when they arise. The network also provides assistance and outreach for small employers seeking information about ACA and their coverage options. The CHA network is organized on a "hub and spokes" model. A central organization coordinates other network organizations, provides training, technical assistance, individual case reviews, and data collection and holds regular meetings where unique cases and emerging issues can be jointly discussed. The community based organizations of CHA specialize in serving target populations – such as neighborhood, ethnic, or income groups – and develop close contacts and trust with their constituents. With support from the central CHA system, these organizations can provide a full range of help to clients.[47]

Massachusetts is another state that has tried to link its assistance programs and entities within an overall structure. In Massachusetts, ACA-like health reforms have been in place since 2006 and 98 percent of state residents are now insured. The state created a centralized Health Reform Outreach and Education Unit to coordinate all consumer outreach and assistance functions. The Outreach Unit coordinates activities of the state's Medicaid program and its health insurance Exchange (the Commonwealth Connector.) It also manages state grant funding for community-based organizations and institutions to conduct outreach and enrollment and trains and provides technical assistance to these grantees. The state's primary nonprofit assistance organization, Health Care For All (HCFAMA), staffs a HelpLine for consumers to help them find and enroll in coverage and resolve coverage problems. HCFAMA also contracts with the state to provide CAP services. For both the HelpLine and the CAP, HCFAMA tracks data on consumer inquiries and complaints and provides feedback to government officials on trouble spots, such as call backlogs and carrier compliance concerns.[48]

Within FFE states, coordination of assistance programs may pose special challenges. The federal government will need to recruit a network of Navigators in each state and, by definition, will not have a state-based Exchange official to help coordinate this network. Navigators may benefit from ongoing contact with federal agency staff, and with each other, in order share best practices and learn from their mutual experiences. However, the amount of federal resources and staffing that will be available for

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[47] Community Service Society, "Making Health Reform Work: Consumer Assistance Programs," September 2010.
[48] Community Service Society, "Making Health Reform Work: Consumer Assistance Programs," September 2010. Also Blue Cross Blue Shield of Massachusetts Foundation, "Effective Education, Outreach, and Enrollment Approaches for Populations Newly Eligible for Health Coverage," March 2012, available at http://bluecrossmafoundation.org/tag/publication-collection/health-reform-toolkit-series

coordination is not yet known. In addition, FFE state Navigators will need to coordinate with state Medicaid agencies – though Medicaid eligibility likely will not be expanded in all FFE states – and with state CAPs – though not all FFE states have CAPs. As a result it may be more difficult for Navigators to coordinate with other assisters; in turn, it may be more difficult for consumers to enroll in coverage or resolve problems. In addition to coordination by the federal government, navigators in FFE states may turn to outside sources of support and networking. For example, following enactment of the State Children's Health Insurance Program (SCHIP), a privately funded effort – the Covering Kids and Families Initiative – organized non-profit organizations and corporate partners in states to promote public education, outreach, and enrollment assistance to expand coverage for children. In addition to recruiting partners, the initiative provided financing and other resources such as outreach tool kits to support these efforts.[50]

Training, Technical Assistance and Oversight

Training of consumer assisters will also be key. Assisters will need to become familiar with new coverage options and financial assistance programs and their eligibility rules and procedures. Various new market rules and consumer protections will also take effect in 2014. Proposed federal rules indicate that assistance training programs will involve 15 modules – including eligibility rules for subsidies, tax implications of enrollment decisions, basic concepts about health insurance, privacy and security standards, and others – to be completed in up to 30 hours.[51]

States can rely on federal training, supplement it, or develop their own training programs. For example, modules might also be developed to anticipate and address specific needs of certain populations. Such modules might target young adults, who may be eligible for different coverage options compared to other individuals, such as "catastrophic" health plans, student health plans, and the option to remain covered as a dependent under their parents' policy. Working individuals may need specialized help understanding health benefits offered by employers, or recognizing how another family member's access to group health benefits affects their own eligibility for subsidies, or navigating job-based and Exchange open enrollment periods if they occur at different times. Immigrants and permanent non-citizen residents of the US may also face unique questions and problems. So might older individuals who are nearing or working past the age of Medicare eligibility.

At least at the outset, training in many states may be somewhat limited. Officials will need to balance the need for very detailed and specific training against costs, the limited time for training before open season begins, and the possibility that training requirements might overwhelm potential assisters.

Whatever their initial training, assisters inevitably will encounter unfamiliar problems and situations and will need to call on a supervisor or other expert for help in order to provide the consumer with accurate and appropriate assistance. In New York's "hub and spoke" model, spoke program staff are trained to

[50] See Robert Wood Johnson Foundation Covering Kids and Families Initiative, http://www.coveringkidsandfamilies.org/about/

[51] Patient Protection and Affordable Care Act: Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel. Proposed rule. April 5, 2013. Available at http://www.gpo.gov/fdsys/pkg/FR-2013-04-05/pdf/2013-07951.pdf

help consumers sign up for coverage and subsidies and navigate insurance changes, while hub program staff provide technical assistance on more difficult cases. Continuing education is also required of assisters. Hub program staff conduct ongoing learning opportunities for spoke organizations, such as webinars and monthly case review meetings to spot trends and help assisters identify issues correctly. [52]

Quality assurance will also be a factor determining the strength of consumer assistance. States and the federal government may adopt different approaches to monitoring the work of consumer assisters in order to identify concerns and the need for remedial training. In some states, assisters who help with eligibility and enrollment may be required to log in to a dedicated web portal that can also track certain case information and outcomes. Periodic audits or case reviews might be instituted. Ensuring that consumers get consistent information, no matter where they seek help, will matter to the success of assistance programs.

Looking to the future

Finally, early experiences providing consumer assistance can yield lessons for the future and can inform efforts by states and the federal government to strengthen programs over time. Feedback from assisters to government agencies may point out what works and what can be improved. Evaluation of different approaches to funding, training, coordinating, and monitoring of assistance programs could measure how these factors impact enrollment rates, persistence of enrollment, and other consumer experiences. To the extent states and the federal government conduct such assessments and share their findings, consumer assistance in the second year of health reform may develop in ways that contribute even further to effective implementation.

[52] Connecting Consumers to Coverage: the Role of Navigators and Consumer Assistance Programs in Implementing Health Reform in New York, September 2011. Available at http://nyshealthfoundation.org/uploads/resources/navigators-consumer-assistance-programs-september-2011.pdf

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ACA Implementation—Monitoring and Tracking

Cross-Cutting Issues:

Factors Affecting Self-Funding by Small Employers: Views from the Market

April 2013

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With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act of 2010. The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform in Alabama, Colorado, Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island, and Virginia to help states, researchers and policymakers learn from the process as it unfolds. This report is one of a series of papers focusing on particular implementation issues in these case study states. In addition, state-specific reports on case study states can be found at www.rwjf.org and www.healthpolicycenter.org. The quantitative component of the project is producing analyses of the effects of the ACA on coverage, health expenditures, affordability, access, and premiums in the states and nationally.

ABSTRACT

Policy experts predict that small employers, especially those with younger and healthier employees, will increasingly establish "self-funded" health plans, leaving the traditional fully insured market to obtain lower premiums and avoid market reforms under the Affordable Care Act. Through interviews with stakeholders in 10 study states, this paper describes factors that may influence whether and how extensively this change occurs. It also shows that states have minimal data on this potentially growing market, but they would be well-served to improve their monitoring efforts so they can identify any increases in small group self-funding and resulting adverse selection, and respond appropriately.

INTRODUCTION AND METHODOLOGY

The Affordable Care Act (ACA) will significantly change the regulatory standards that determine the accessibility, affordability, and adequacy of private health insurance coverage in the small group market. While these changes are intended to improve market conditions and the generosity of coverage for small employers, they could increase the cost of insurance for some small employers. Policy experts have speculated that such cost increases—and some of the new regulatory standards—may encourage small employers to establish "self-funded" health plans and leave the fully insured market, thus avoiding a number of the ACA's requirements, such as modified community rating, coverage of essential health benefits, limits on cost sharing, and the health insurer fee. However, most small employers would need to acquire stop-loss coverage—an insurance policy that operates like reinsurance and is typically underwritten by health, gender, and other factors—to help manage the financial risk inherent in self-funding. Thus, whether affordable stop-loss coverage is readily available to small employers could determine whether significant numbers of small employers turn to self-funding. Because self-funding may be particularly attractive to younger and healthier groups, a large increase in self-funding could cause adverse selection against the fully insured small group market, including but not limited to, the small business health options program (SHOP) exchanges.

This paper explores this premise through in-depth telephone interviews with small employer representatives, producers (agents and brokers), health insurers, stop-loss insurers, and state officials including insurance

regulators and exchange representatives in the 10 states participating in the Robert Wood Johnson Foundation's monitoring and tracking project (Alabama, Colorado, Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island, and Virginia). The authors reviewed statutes, regulations and guidance across the 10 states and conducted interviews with nearly 50 informants between October 2012 and January 2013.[1] This paper provides an assessment of the informants' perspectives on the current and future market for small group self-funding and the sale of stop-loss coverage.

Informants provided insight into the current status of self-funding among small employers and, looking ahead, the factors that may influence whether more small employers will self-fund in response to implementation of the ACA's market reforms. In addition, informants emphasized that the magnitude of market changes will depend on the definition of small employer—which will expand from firms with 50 or fewer employees, to those with up to 100 employees in 2016. These findings are limited, however, by the lack of publicly available data on the number of employers currently covered under stop-loss policies and the attachment points under which these policies are being sold.

Exhibit 1: Key Definitions

Term	Definition
Self-funded health plan (also known as self-insured health plan)	A plan for which the plan sponsor (e.g., employer) generally takes on the financial risk of paying claims for covered benefits.
Fully insured health plan	A plan for which the plan sponsor (e.g., employer) generally purchases health insurance coverage from an insurer who takes on the financial risk of paying claims for covered benefits.
Stop-loss insurance	An insurance policy that operates like reinsurance to reimburse sponsors of self-funded plans for claims above a specified level.
Self-funding arrangement	A bundled package that combines stop-loss insurance with other services required to properly administer a health plan, such as access to a provider network and claims processing.
Specific attachment point (also known as specific deductible)	The dollar amount, under the policy terms, where the insurer begins paying for claims incurred by an individual covered by a stop-loss policy and the employer's liability ends.
Aggregate attachment point	The dollar amount, under the policy terms, where the insurer begins paying for claims incurred by a group covered by a stop-loss policy and the employer's liability ends.
Producer	An agent or a broker.

BACKGROUND

Employer-sponsored health coverage generally is provided through one of two funding arrangements. Under the first, an employer purchases a health plan from an insurer who bears the financial risk of paying claims for covered benefits. Under the second, an employer may self-fund (or self-insure) a health plan. In this case, the employer takes on the risk of providing health benefits to plan enrollees. To protect against large, unexpected claims in a given year, however, an employer may reinsure its self-funded health plan by purchasing stop-loss insurance. Depending on state law, stop-loss insurance can be sold by insurers that specialize in either stop-loss or those that offer other forms of insurance. Typically stop-loss insurance will begin to cover claims after a

pre-determined amount, referred to as an attachment point. Stop-loss contracts may include individual-level (specific) and/or group-level (aggregate) attachment points.

Under the Employee Retirement Income Security Act (ERISA) and other federal laws, the federal government regulates employee health benefit plans, including self-funded plans, but does not regulate or collect data on the sale of stop-loss policies purchased by employers operating self-funded plans.[2] States, on the other hand, are prohibited from regulating employer health benefit plans under ERISA; they may only regulate insurance contracts that employers buy directly to provide benefits to their employees or to reinsure their self-funded plan. Therefore, a state may not prohibit an employer from self-funding or set rules for the coverage provided by a self-funded plan, but it is generally understood that a state may regulate a stop-loss policy as insurance.[3]

Among states that have taken regulatory action, approaches vary—such as setting minimum attachment points; banning the sale of stop-loss coverage to small employers; or regulating stop-loss coverage sold to small employers under the same rules that apply to fully insured plans sold in the small group market, such as underwriting and rating rules.

Self-funding has traditionally been more common among larger employers than small employers. Large groups usually have more resources and can spread the risk of high claims across a bigger pool of people than small employers can.[4] However, some policy experts speculate that self-funding could become more attractive to certain small employers as the ACA's market reforms go into effect.[5] By self-funding, a small employer could bypass some of the ACA's market reforms that apply only to the fully insured market, such as modified community rating, coverage of essential health benefits, and limits on cost sharing, as well as the health insurer fee, which does not apply to self-funded health plans. While these changes are intended to improve market conditions and the generosity of coverage for small employers, they are expected to increase the cost of insurance for some small employers, particularly those with younger and healthier workforces. Such employers may be able to save money by self-funding and purchasing more affordable stop-loss—which, in most states, insurers are allowed to underwrite based on health, gender, and other rating factors—only to re-enter the fully insured market if their health status declines at any time in future years. Bundled "self-funding arrangements" that offer significant financial protection through low attachment points and are designed to resemble traditional health insurance by building a provider network, claims processing, and other administrative services required to properly administer a health plan into a single administrative services contract[6] may be particularly appealing to small employers.

If low-attachment point coverage is widely available, a large number of small groups with healthier risk profiles may turn to self-funding. Economic models by the Urban Institute indicate that if this happens, there may be significant adverse selection against the small group fully insured market, increasing premium costs and potentially reducing the number of healthy covered lives in the fully insured small group market, including the SHOP exchanges.[7] However, because most small employers will not self-fund without the financial protection provided by stop-loss coverage,[8] regulating stop-loss insurance could be an effective way for states to limit the reach of self-funding into the small group market, if they determine it necessary or appropriate.

Regulation of stop-loss coverage sales to small employers

In 1995, the National Association of Insurance Commissioners (NAIC) adopted a model state law setting minimum specific and aggregate attachment points for stop-loss coverage.[9] Higher attachment points may dissuade some small employers from self-funding by exposing employers to greater risk than they would face with policies with low attachment points. For instance, while large employers may be able to tolerate the risk exposure of a stop-loss plan with a $60,000 or $100,000 specific attachment point, most small employers will likely find these points to be too high. On the other hand, a small employer may be more willing and able to self-fund if it can purchase stop-loss coverage with lower attachment points, which can be legally sold in states that do not regulate stop-loss coverage.

Most states, however, have not enacted the NAIC model law, and only a minority of states has otherwise attempted to regulate stop-loss coverage. Among states that have taken regulatory action, approaches vary—such as setting minimum attachment points; banning the sale of stop-loss coverage to small employers; or regulating stop-loss coverage sold to small employers under the

same rules that apply to fully insured plans sold in the small group market, such as underwriting and rating rules. The 10 states studied here are more aggressive than average in the regulation of stop-loss; however almost half—Alabama, Michigan, New Mexico, and Virginia—do not impose standards on stop-loss policies sold to small employers. Of the study states that have taken regulatory action, New York and Oregon prohibit the sale of stop-loss coverage to small employers altogether, while Colorado,[10] Maryland,[11] and Minnesota[12] have set minimum attachment points for the sale of stop-loss coverage. Rhode Island regulators report that they apply minimum attachment points consistent with the NAIC model law when reviewing stop-loss policy forms, although these standards are not specified in state law.

A few states, including Colorado and Minnesota, have additional regulatory standards that may limit the sale of stop-loss coverage to small employers. In Colorado, small employers re-entering the fully insured small group market after being covered under certain self-funding arrangements may face a premium surcharge of up to 35 percent above the required modified community rating that they would otherwise be charged.[13] In Minnesota, stop-loss policies issued to small employers are required to cover all claims incurred during the contract period regardless of when the claims are paid. This protects employers from claims above their specific or aggregate attachment points that were incurred during the plan year but not submitted or processed until after the end of their stop-loss plan year.[14]

OBSERVATIONS FROM THE 10 STATES

In-depth telephone interviews with small employer representatives, producers, health insurers, stop-loss insurers, and state officials, including insurance regulators and exchange representatives, in 10 states revealed that the vast majority of stakeholders have some level of concern about the prospect of employers with 50 or fewer employees self-funding. There is less unanimity, however, regarding the likelihood of self-funding by small employers increasing on a wide scale. Although data are minimal, interviews and anecdotal evidence suggest that most insurers and producers do not currently sell stop-loss insurance policies or self-funding arrangements that integrate stop-loss coverage to small groups and that few small employers self-fund today. Looking ahead, informants indicate that the extent to which small employers begin self-funding in 2014 and the effect this may have on the traditional small group market and SHOP exchanges will depend on a number of interconnected factors. These factors include insurers' interest in marketing stop-loss coverage or related self-funding arrangements to small employers, producers' willingness to sell such coverage options to small employers, small employers' interest in self-funding compared to other coverage options or not offering coverage at all, and states' regulation of stop-loss policies sold to small employers. In addition, informants emphasized that the magnitude of market changes will depend on who is considered a small employer—a definition that will expand from groups of 50 or fewer employees to groups of up to 100 employees in 2016.

Informants largely consider self-funding inappropriate for small employers.

Informants generally agreed that the most likely candidates for self-funding would primarily be employers who are financially secure and sophisticated—employers typically need to have enough money to set up a reserve to handle high medical claims—and who are comfortable taking on risk. Self-funding also may appear particularly attractive to employers providing coverage to healthier or younger groups who do not expect to have significant medical claims. However, most informants—insurance company representatives, producers, and regulators alike—emphasized that self-funding, even with stop-loss coverage, could expose small businesses to considerable, and unpredictable, financial and legal risks.

Regulators largely panned self-funding by small employers. According to an Alabama regulator, "If I had a small business, I wouldn't even think that way because only one or two claims could bankrupt you." Regulators in Minnesota commented that many small employers are ill-equipped to purchase stop-loss coverage, noting complaints from employers who were unaware of the full liability they faced under their policies. Similar sentiment was expressed by other stakeholders. A New York producer called it "malpractice" to advocate self-funding for small groups, while a producer from Virginia commented that businesses with fewer than 100 employees "have no business self-funding." A health insurer representative said that self-funding never

starts out as someone's first choice, adding that "many employers understand that it works well until it doesn't."

One reason given for such attitudes is informants' experience with small employers who were offered an inexpensive stop-loss policy in their first year, only to see significant rate increases in later years. A former producer in Colorado estimated that 10 to 15 percent of self-funded employers will face re-underwriting—screening by their stop-loss insurer to assess their health status and risk factors—within a couple of years and may face significant premium increases due to changes in their employees' health status. Another producer reported that insurers may re-underwrite a group if the employee population fluctuates more than 10 percent in a year. Further, stakeholders familiar with stop-loss contracts—including state officials and insurance representatives—pointed out that under some stop-loss policies a small business may be responsible for the "run out"—the full cost of any claims incurred while covered by a stop-loss policy but not processed until after the policy had expired. Thus, while employers may switch to a fully insured plan after their group's health status declines, they may remain liable for large claims that were incurred when they were self-funded.[15]

Insurers and producers also expressed concern that most small employers do not have the in-house expertise to take on the legal liability of self-funding.

In addition, while stop-loss policies marketed toward small groups are likely to include low attachment points to limit an employer's financial exposure, multiple stakeholders indicated that such plans would not necessarily take all the risk out of self-funding. A state regulator commented that "even a $15,000 specific attachment point is a big hit to a very small employer." A producer noted that stop-loss policies with low attachment points also may include contractual provisions called "lasers" that exempt high-risk employees from coverage by the stop-loss policy or subject them to higher specific attachment points. According to a producer from Oregon, another classic problem encountered with a stop-loss policy is that pharmacy claims may not be covered, leaving an employer fully exposed for the cost of any pharmaceutical benefits included in its group health plan. In addition, a producer reported that stop-loss insurers often do not pay claims above the stop-loss policies' attachment points until the end of the first quarter of the subsequent year. Consequently, the employer would need to pay the full claim out of pocket and may not be reimbursed for up to 15 months.

Insurers and producers also expressed concern that most small employers do not have the in-house expertise to take on the legal liability of self-funding. One insurer in New Mexico commented, "A typical small employer is wheeling and dealing each day, and doing their company's finances in their head. I see all kinds of risk for them to unintentionally break some rule under ERISA." A New Mexico producer agreed, noting that "brokers need to know their stuff in terms of compliance to not get their clients in trouble."

However, a number of informants suggested that self-funding can have benefits for certain employers who want to take a hands-on approach to designing their plan. In particular, producers and stop-loss insurers claimed that sophisticated employers could leverage their access to health care claims data to identify cost drivers within their group. Self-funding can provide employers with benefit design flexibility, allowing them to attempt to reduce their costs through wellness programs, network design, health education, and other strategies. However, other informants questioned the ability of small groups to generate sufficiently robust data to meaningfully identify cost trends or implement effective cost containment strategies.

Data are scant, but most informants believe that the sale of stop-loss policies or self-funding arrangements to small employers is currently minimal.

State officials in the study states acknowledged that they are not currently monitoring how much stop-loss coverage is being sold to small employers. Insurers are typically required under state law to file stop-loss policies with departments of insurance, in which case regulators have on file the name of the insurers that have been approved for the sale of stop-loss coverage and the form that was reviewed by regulators for compliance with state law. In some cases, this may include minimum attachment points and the size of the group to which the policy is intended to be sold. However, no state official was able to report the number of small employers currently covered under stop-loss policies. State officials

generally reported relying on either anecdotal evidence from insurers or, to the extent available, consumer complaints to inform them of the status of the small employer stop-loss market. One state official noted, "We don't have a way to monitor this. We hear from [health] insurers that they're losing customers to stop-loss [insurers], but we haven't been able to confirm." Another stated that she had never been asked for a report on the amount of self-funding in the small group market. One former state regulator indicated that it would not be difficult for state departments of insurance to collect more information through a data call, but that such steps may draw negative reactions and questions from stakeholders. Only in Rhode Island did officials indicate that they planned to begin collecting data on this market more closely in the near future.

Both regulators and insurers in other states, including those that set minimum attachment points for stop-loss coverage…and those that do not…suggested that they believe that the sale of stop-loss policies to small employers currently makes up only a very small segment of the market.

Lacking data, informants in most states provided anecdotal evidence that traditional health insurers limit their participation in the self-funding market to large employers. Producers in multiple states claimed that many major health insurers have been unwilling to sell stop-loss policies or related self-funding arrangements to employer groups below 100 to 200 people. The primary reason given for this reticence was competition. As one Colorado producer explained, traditional health insurers "don't want to cannibalize existing business. Their primary concern is maintaining current profit margins." An exchange official also noted that these health insurers control the fully insured small group market, which is generally profitable, and would be undercutting themselves if they began pushing products that encourage small employers to self-fund.

A number of informants—including insurers, producers, and state officials—also reported that some insurers believe that the sale of stop-loss coverage or related self-funding arrangements to small employers is not financially worthwhile. Stop-loss insurers specifically argued that while they might be able sell more policies if they lowered their minimum specific attachment points to a level that would attract smaller-sized employers, the number of claims would rise, and the administrative costs to handle such a large volume of claims would increase significantly. Ultimately, one representative concluded, "it's just not worth [it financially]." In Alabama, for example, a producer reported that he works with six to eight stop-loss insurers, but only one will handle a group under 50. However, other producers reported that selling self-funded arrangements to smaller groups can be profitable with the right business model.

Informants also reported that only a small subset of producers is currently selling stop-loss coverage or related self-funding arrangements to groups of 50 or fewer employees. Two former producers said they would have been hesitant to jeopardize the financial security of their smaller clients by moving them to self-funding. Many other informants—including current producers, regulators, and insurers—described the inherent complexity of the product acts as a barrier discouraging producers from pushing self-funding to small employers. According to a number of stakeholders, producers must be very sophisticated to understand complicated stop-loss contracts and determine that all the right components—including provider networks, benefit administrators, and financial reserves—are in place to ensure that a small employer is properly and adequately self-funded. Even when a self-funded arrangement is already bundled, some producers pointed out that it still requires a high level of expertise to understand the financial and legal risks for their employer clients.

Perhaps unsurprisingly then, informants in most study states speculated that the current sale of stop-loss policies to small employers, and thus self-funding, is minimal. In Oregon and New York, which prohibit the sale of stop-loss policies to small employers, state officials have not received any complaints or other information to suggest that insurers are violating the law by marketing or selling stop-loss policies to small employers. Both regulators and insurers in other states, including those that set minimum attachment points for stop-loss coverage (such as Minnesota and Rhode Island) and those that do not (such as Alabama, Michigan, New Mexico, and Virginia) suggested that they believe that the sale of stop-loss policies to small employers currently makes up only a very small segment of the market. Even in Colorado, which has had a long history of insurers marketing stop-loss coverage and self-funding arrangements to medium-to-large employers,

regulators, exchange officials, producers, and small business representatives suggested that there is limited sale of these arrangement to employers with fewer than 35 employees. Explaining this, one informant from Colorado suggested that "the current small group self-funding market employs very aggressive underwriting, and therefore actually writes only a small portion of cases submitted to it."

Insurers monitor the small group market for potential post-ACA expansion.

Implementation of the ACA's market reforms in 2014 may sufficiently change the incentives for stakeholders and cause them to reconsider the feasibility of self-funding by groups of 50 or fewer employees. Some informants highlighted signs that insurers are reconsidering the value of selling stop-loss policies or self-funding arrangements to small groups and are "preparing to turn the switch

As one insurer in New Mexico put it: "Strategically we would not want to be proactive about moving business from fully insured to a self-funded model, because our core business is fully insured HMO and PPO products. It's what we prefer to do. But, if there was a pull from the market to go in that direction, we would follow it."

on with the ACA coming next year." Indeed, it appears that a small set of insurers—including a small number of traditional health insurers as well as some stop-loss insurers—have recently begun aggressively targeting small groups for bundled self-funding arrangements. As evidence of this, a number of informants reported that they had seen an increase in marketing materials for self-funding arrangements targeting groups with 50 or fewer employees and, in some cases, groups as small as five employees.[16] Multiple informants also reported that a national health insurer has invested heavily in developing self-funding arrangements that specifically appeal to small employers and at least one more may be following suit in some states.

According to one producer, such bundled packages attempt to address two major barriers to self-funding faced by small employers. First, these packages minimize the administrative burden of separately contracting and paying for a range of administrative services—such as a pharmacy benefits manager, a provider network, and disease management services—by bundling them together under one policy. Second, these self-funding arrangements aim to limit small employers' exposure to random peaks and valleys in claims, which can disrupt monthly cash flow. Specifically, rather than holding reimbursement for claims that go above the small employers' specific attachment point until the end of the plan year, such arrangements provide immediate reimbursement to small employers. In addition, instead of limiting a small employer's financial exposure for its group's aggregate claims annually, these self-funding arrangements limit a small employer's aggregate exposure monthly. This means that if there is a bad outbreak of the flu in a given month or other peaks in aggregate costs, a small employer would need to cover claims only up to a set aggregate monthly amount rather than the annual aggregate, enabling the employer to spread claims costs out more predictably over the course of the year. The employer and insurer would then come to a settlement at the end of the year to account for any excess claims paid by the stop-loss insurer if the group did not meet its annual aggregate amount.

Importantly, though, informants noted that the issuers offering these self-funding arrangements may be more willing to enter the small group stop-loss market than other health insurers, because they have not been active in the fully insured small group market, and are thus not cannibalizing their own products. Whether additional health insurers will move into the small group stop-loss market is less clear at this stage. A representative from one health insurer in Virginia admitted that the insurer was concerned about changes to the market, but did not want to overreact and, for now, is carefully watching developments related to self-funding among small employers. A Maryland exchange official expressed skepticism that traditional health insurers would change their entire business model just to get into the stop-loss market when the uptake may be small. Other insurance representatives felt that while most insurers in the traditional small group market would rather continue to sell fully insured policies, they may need to begin selling stop-loss policies in order to stay competitive and retain market share. As one insurer in New Mexico put it: "Strategically we would not want to be proactive about moving business from fully insured to a self-funded model, because our core business is fully insured HMO and PPO products. It's what we prefer to do. But, if there

was a pull from the market to go in that direction, we would follow it."

Reports varied across the states regarding whether more health insurers are moving into the stop-loss market for small employers. Regulators and exchange officials from Maryland, New Mexico, and Rhode Island were unaware of increased interest in selling stop-loss coverage or self-funding arrangements among health insurers in their state, but they acknowledged that insurers may be exploring options without telling them. A Colorado

As premiums in the small group market continue to rise, producers are looking for more affordable alternatives they can present to hold onto existing clients or, perhaps more important, attract new clients.

exchange official speculated that health insurers probably have a product line in the works, noting "when you talk to them, they just give you a knowing look." A stop-loss insurance representative agreed, predicting that insurance executives would file new stop-loss policies just in case. Indeed, this may already be happening in at least one state: Michigan regulators confirmed that they had seen an uptick in stop-loss product fillings for the small group market in recent years, including stop-loss policies with specific attachment points as low as $5,000. However, one producer suggested that insurers will file policies with attachment points as low as legally allowed to afford themselves maximum flexibility to accommodate market dynamics, even if they do not currently intend to sell policies at that level. While review of product filings can be indicative of market trends, it does not offer a complete picture of the market.

Producers see new opportunities and challenges to selling stop-loss and self-funding arrangements to small employers.

Despite the challenges of packaging self-funding arrangements and explaining the risks and complexities of self-funding, many stakeholders predicted that more producers may consider entering the self-funding market in order to stay competitive. As premiums in the small group market continue to rise, producers are looking for more affordable alternatives they can present to hold onto existing clients or, perhaps more important, attract new clients. While some current and former producers indicated that compensation for selling stop-loss coverage may match or exceed that for fully insured plans, other producers and insurers believed the compensation was lower, in part because premiums for stop-loss coverage are significantly lower than for fully insured coverage. (Producer compensation is often calculated as a preset percentage of the premium.) In the latter case, producers may offer stop-loss policies or self-funding arrangements to increase market share, but not necessarily to convert existing clients from one type of business to another.

A few stakeholders specifically pointed to elements of the ACA as a reason more producers may turn to selling stop-loss coverage or self-funding arrangements—indeed, one producer representative reported that a small number of "self-funding activists see the ACA as a different opportunity to carve out a niche for themselves." Producers in Maryland and Oregon identified the creation of exchanges as a particular concern. In Maryland, producers feared that the exchange would limit their compensation, potentially making self-funded coverage options more attractive. A stop-loss insurer also indicated that producer compensation for selling stop-loss policies and self-funding arrangements could rise relative to compensation for traditional health insurance because self-funded plans are not subject to the ACA's medical loss ratio (MLR) rules. The MLR standard, implemented in 2011, requires health insurers to issue rebates to policyholders if their administrative costs are too high relative to their premium revenue. It has pressured insurers to become more efficient in their operations, and some have responded by reducing producer compensation.

Once a critical mass of producers in a market starts offering stop-loss coverage or self-funding arrangements, others may be compelled to follow suit. As one Maryland producer put it, "A broker would be committing professional suicide by showing one [coverage option], but failing to show another." Yet, while stakeholders sensed that some insurers and brokers are increasingly interested in selling stop-loss or self-funding arrangements, the extent of actual changes in producer behavior and market impact remains in question. In Colorado, one producer expected that more producers will begin offering these coverage options to small groups, but he commented that it would remain a very slim market segment and did not expect that producers would pursue groups under 30 or 35 for self-funding.

Even in states home to "self-funding activists," who see a business opportunity in marketing self-funded plans to small employers, producers reported that most of them would like to see business as usual and to continue offering traditional insurance products rather than self-funding arrangements.

How small employers will respond to the changing marketplace remains unclear.

Informants widely agreed that small businesses are frustrated by rising insurance premiums and open to opportunities to limit their and their employees' costs. Coupled with this frustration is a tremendous amount of confusion among small employers about their options. According to one informant, small businesses "are just nervous wrecks" who may be open to the idea of saving money and avoiding new regulations by self-funding. Nonetheless, small business representatives in Alabama, Colorado, Minnesota, and Oregon reported that they had not yet encountered any increase in interest in self-funding among small employers, and most informants were uncertain of the extent to which rates of self-funding would increase among smaller groups.

> *Various stakeholders suggested that defined contribution, in particular, would be a more appealing model than self-funding for small groups.*

Many commented that they simply cannot predict what will happen until they have a better understanding of what the market will look like in 2014. Informants generally agreed that health insurance costs—and, in particular, the possibility of premium increases for younger, healthier small groups—will play an important factor in small businesses' decisions in a post-reform environment. Self-funding could become an increasingly attractive option to those groups, especially if marketed with an affordable self-funding arrangement that minimizes their exposure to financial risk. Informants indicated that it will be particularly important to watch whether more insurers create self-funding arrangements that take much of the risk out of self-funding, are easier to understand, and, from the employer perspective, look very similar to the traditional fully insured health insurance. As one producer in Oregon described such arrangements: "They offer the full meal deal. You get your burger, your fries, and your toy all in one package." While such packages may cost more than traditional methods of self-funding, the cash-flow protection they provide may make them more viable options for small employers. A small employer's maximum monthly costs with a bundled package may not be significantly greater than the premium for fully insured plans and, if claims are low, may be much less. At the same time, the appeal of self-funding arrangements may depend on fine details within the contracts. Producers and health insurers in New Mexico, where bundled packages have popped up in the past, indicated that small employers could still get "bitten in the end" and be liable for large claims at the end of the contract year, as in any other stop-loss policy. In such cases, if small employers want to return to the traditional fully insured market, they may need to pay premiums for the new plan while still paying claims on their old policy.

Informants also indicated that self-funding may just be one of a range of options that will be available to small employers. Various stakeholders suggested that defined contribution, in particular, would be a more appealing model than self-funding for small groups. Although small employers typically contribute a set percentage to their employees' premium costs, meaning their costs rise as premium costs rise, a defined contribution model would allow them to specify a flat dollar amount as their premium contribution. They then get to decide whether to increase that dollar amount in future years. According to one informant, "Employers just want to say, 'Here is $500/month for health insurance, go away.'" Informants in multiple states also reported an increase in the purchase of high deductible health plans at lower premiums than traditional health plans, while limiting their employees' out-of-pocket costs by funding health reimbursement arrangements (HRAs) to fill in all or a portion of the deductible. A Rhode Island exchange official expressed concern that while groups doing this are not taking themselves out of the fully insured market, it may serve as a stepping stone towards self-funding. In addition, informants in multiple states raised concerns about producers pushing other arrangements that may incorporate self-funding, such as medical stop-loss captives and professional employer organizations (PEO).[17] In Alabama, for instance, one producer indicated that he was forming a captive by pooling several small groups together and arranging with a stop-loss insurer to reinsure the entire group collectively. Small employers also may elect to drop coverage altogether without penalty, as the ACA's employer responsibility requirements do not apply to groups with 50 or fewer

employees. And, under the ACA's insurance reforms, their employees will, for the first time nationwide, have guaranteed access to subsidized insurance through the exchanges.

How these different options stack up against self-funding will depend in part on how stop-loss coverage and self-funding arrangements are communicated to small businesses. A range of informants—including current and former producers—expressed doubt that producers are always adequately explaining the risks of self-funding to small employers. One regulator reflected on prior experience with increases in self-funding among small groups, noting "If the small employers walked in eyes wide open, then fair enough, but I think a lot of them walked in with no idea and had not been appropriately guided." Small employers may be more likely to self-fund when they are not fully informed of their potential financial and legal exposure under such arrangements.

Expansion of the regulation of stop-loss to small employers is a low priority before 2014.

While they acknowledged that a significant increase in self-funding among small employers could destabilize the small group market and undermine the SHOP exchanges, neither state regulators nor state exchange officials identified the further regulation of the sale of stop-loss as a primary concern. Informants largely reported that further state action was unlikely before full implementation of the ACA.[18]

According to many informants, state inaction on stop-loss was due in part to a lack of capacity. Most study states are developing state-based exchanges and are focused on the mechanics of standing up their SHOP exchanges. State officials generally reported having limited time to focus on issues related to adverse selection against the exchange. As one small business representative active in exchange discussions in Colorado noted, "adverse selection [against the SHOP] is a downstream issue" and "right now, we are still trying to get our sea legs and get [the SHOP] up and running." This response did not surprise one major insurer in Maryland who noted that "States have a lot on their hands, and they don't have the bandwidth to focus on issues that are not of the utmost urgency at this time." This informant added: "There are so many pieces of health reform that need to get done, not only for the regulators, but also for the insurers, so nobody is paying that much attention to this right now."

In addition, state officials seem to regard the sale of stop-loss coverage and self-funding of small employers as a "tertiary adverse selection issue," and are instead focusing on how they can make the SHOP appealing to small groups in the first place. In Rhode Island, officials are focused on how to structure the SHOP to ensure that it offers plans and services that attract enough small employers to be self-sustaining in 2014. Instead of concentrating on how to eliminate options that may be offered outside the exchange, Rhode Island is concentrating its efforts on implementing an employee choice and defined contribution model that will attract small employers to the SHOP. As one state official noted, "Our approach is to do what is absolutely necessary, not necessarily what is needed for broader fixes to the market."

A number of state officials also noted that state legislatures are typically reluctant to engage in regulatory solutions before there is a defined problem. One state exchange official described the prediction of increased self-funding among small employers as a "hypothetical," and another informant noted that "most governments aren't going to deal with this preemptively." In addition, it was suggested that moving forward to further regulate the sale of stop-loss would be the "the third rail" politically. That being said, a number of regulators and exchange officials suggested that clear data demonstrating a significant increase in self-funding among small employers to the detriment of the small group market and SHOP exchange may trigger state action down the road, especially in states that are standing up an exchange. For example, in Rhode Island, a state official offered that if self-funding among small employers becomes a "defined problem" that is "causing harm to the SHOP" or "having an impact on the costs and trends of the small group market," then the state may be spurred to action.

Expanding definition of small group may further complicate the stop-loss discussion in 2016.

In 2016, under federal law, the definition of the small group market will expand to include businesses with 51 to 100 employees. This will enable groups of this size to purchase health insurance in the small group market and through the SHOP exchanges on a guaranteed issue basis. They will also be newly subject to the ACA's small group market reforms, including the adjusted community rating rules, coverage of essential health benefits and limits on cost sharing. This change also may

complicate the discussion over whether it is necessary or appropriate to regulate the sale of stop-loss coverage to small groups.

With these changes, informants often reported that they expect to see increases in self-funding by employers with more than 50 employees. For instance, Rhode Island officials suggested that the 51 to 100 market—where groups are mostly experience-rated and some of the healthier and younger groups could face increases in premiums under the ACA's rating reforms—may be more inclined to self-fund than employers in the current small group market, which is already subject to adjusted community rating. Stakeholders in New Mexico agreed; one producer note that groups over 50 are used to being underwritten, confronting lasers, and coverage denials, so "they might as well take on more risks to avoid the taxes and fees in fully insured coverage." A Minnesota small business representative thought employers with 51 to 100 employees are the more "natural audience" for self-funding, given their exposure to the ACA's employer responsibility requirements.

Informants were also often less concerned about employers with more than 50 employees self-funding than employers with 50 or fewer employees self-funding. As one producer described, if a business has survived long enough to have 60 or 80 employees, it is more likely to be financially and operationally ready for self-funding. Industry representatives also indicated that more insurers and producers are willing to sell stop-loss to this market than to smaller groups, and others may follow suit. In Oregon, a state official acknowledged that many groups in this market are already self-funding with the bundled arrangement described previously. At the same time, a growth in self-funding among these larger small employers would likely increase the risk of adverse selection against the fully insured small group market in 2016. State officials generally did not speculate on if or how they would address this issue if it arose.

CONCLUSION

In interviews with key stakeholders, most informants did not believe that insurers and brokers are currently selling stop-loss insurance to small groups, beyond a few niche sellers. None of the informants thought that small employers are self-funding in any significant numbers. However, insurance regulators and policy-makers are hindered by a lack of data, with no state able to report the actual number of small employers covered under stop-loss policies or the terms under which those policies are being marketed.

Most informants expressed concern that self-funding exposes small businesses to too much financial and legal risk. While some speculate that healthier small groups may increasingly be driven to self-funding because of the ACA's market reforms, informants indicated that a number of variables will influence employers' decisions and were hesitant to make firm predictions of what the 50-and-under market will look like in 2014 and later years. Many informants agreed, however, that groups between 51 and 100 employees are more likely to self-fund in greater numbers when they become subject to the small group market reform rules in 2016.

Given the uncertain future of the small group market and number of other pressing health insurance reform responsibilities facing state legislatures, departments of insurance, and the exchanges, informants widely reported that prohibiting or otherwise expanding regulation of the sale of stop-loss insurance to small employers is a low priority in the near future. Instead, many informants acknowledged that states would be well served to improve monitoring of the stop-loss market and trends in self-funding by small groups, so they can identify if changes in the marketplace are occurring and respond appropriately. At a minimum, state departments of insurance could collect data on the number of small employers self-funding, the number of small employers purchasing stop-loss insurance, and the attachment points of policies sold to small groups.

About the Authors and Acknowledgements

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The Center on Health Insurance Reforms at Georgetown University's Health Policy Institute is a nonpartisan, expert team of faculty and staff dedicated to conducting research on the complex and developing relationship between state and federal oversight of the health insurance marketplace.

ENDNOTES

1. To gather qualitative research using a convenience sample, interviews were conducted with 22 state officials, including regulators, exchange officials, and others; eleven representatives of health and stop-loss insurers; ten current and former producers; and five small business representatives.
2. While the federal government does collect data related to self-funding among employers that cover groups of over 100 employees, these data do not specify whether employers are relying on a stop-loss policy to self-fund. Solis HL, "Report to Congress: Annual Report on Self-Insured Group Health Plans" (Washington: Department of Labor, April 2012), available at http://www.dol.gov/ebsa/pdf/ACAReportToCongress041612.pdf.
3. Experts note that state efforts to regulate stop-loss insurance may continue to face ERISA pre-emption challenges. For a full discussion, see, for example, Jost TS and Hall MA, "Self-Insurance for Small Employers under the Affordable Care Act: Federal and State Regulatory Options," NYU Annual Survey of American Law, forthcoming, Washington & Lee, Legal Studies Paper No. 2012-24 (Jun. 2012); and Korobkin R, "The battle over self-insured health plans, or one good loophole deserves another," Yale Journal of Health Policy, Law, and Ethics 1,UCLA School of Law Research Paper No. 04-2 (Winter 2005).
4. According to one recent analysis, the rate of self-funding by firms with fewer than 50 employees has hovered around 12 percent for over a decade, while the rate of self-funding by firms with 50 or more employees increased from 49.5 percent in 1999 to 68.5 percent in 2011. See Fronstin P, "Self-Insured Health Plans: State Variation and Recent Trends by Firm Size," Notes 33, n. 11 (Nov. 2012), available at http://www.ebri.org/pdf/notespdf/EBRI_Notes_11_Nov-12.Slf-Insrd1.pdf.
5. See, for example, Yee T, Christianson JB, and Ginsburg PB, "Small Employers and Self-Insured Health Benefits: Too Small to Succeed?" Center for Studying Health System Change, Issue Brief 138 (Jul. 2012), available at http://www.hschange.com/CONTENT/1304/; and Jost and Hall.
6. Employers, large or small, that purchase a stop-loss policy require access to a provider network, claims processing, and other administrative services required to properly administer a health plan. Some employers obtain these services through separate contracts; others buy them as a bundled package from a third-party administrator, who may also be the stop-loss carrier.
7. Buettgens M and Blumberg LJ, "Small Firm Self-Insurance Under the Affordable Care Act," Commonwealth Fund, Pub. 1647 (Nov. 2012), available at http://www.commonwealthfund.org/Publications/Issue-Briefs/2012/Nov/Small-Firm-Self-Insurance.aspx.
8. Hall MA, "Regulating Stop-Loss Coverage May Be Needed To Deter Self-Insuring Small Employers From Undermining Market Reforms," Health Affairs, 31, no. 2 (2012), available at http://content.healthaffairs.org/content/31/2/316.abstract
9. The NAIC Model Act prohibits insurers from issuing a stop-loss policy with an attachment point less than $20,000 per person per year or that provides direct coverage of an individual's health expenses. Aggregate stop-loss for groups of more than 50 may not be less than 110 percent of expected claims. For groups of 50 or less, aggregate stop-loss may not be less than the greater of $4,000 times the number of group members, 120 percent of expected claims, or $20,000. See "Compendium of State Laws on Insurance Topics," National Association of insurance Commissioners (Feb. 2010).
10. Colorado applies a minimum specific attachment point of $15,000 and a minimum aggregate attachment point of 120 percent of expected claims for the small group market.
11. Maryland applies a minimum specific attachment point of $10,000 and a minimum aggregate attachment point of not less than 115 percent of expected claims.
12. Minnesota has applied a minimum specific attachment point of $20,000 and a minimum aggregate attachment point of not less than the greater of $4,000 times the number of group members, 120 percent of expected claims, or $20,000.

13. See C.R.S. 10-16-105 (13). This requirement, however, may be pre-empted in 2014 by the Affordable Care Act, which allows rate surcharges based only on age, tobacco use, geographic location, and family size.
14. A contract providing stop-loss coverage, issued, or renewed to a small employer, as defined in section 62L.02, subdivision 26, or to a plan sponsored by a small employer, must include a claim settlement period no less favorable to the small employer or plan than coverage of all claims incurred during the contract period regardless of when the claims are paid. See Minn. Stat. § 60A.236.
15. Such an employer, however, may have seen no or very few claims in the first two months of its policy (the "run in") because of the typical delay in medical bills being submitted and paid. An employer that is aware of its liability at the end of the contract year could bank any "run in" savings to cover the "run out."
16. This is consistent with observations made by experts analyzing the market. See, for example, Jost and Hall.
17. Similar to captive property/casualty programs, medical stop-loss captives allow self-funded employers to pool part of their excess medical claims costs with other like-minded companies and then purchase commercial stop-loss coverage at higher attachment points. PEOs contract with client organizations to provide human resources management, including services such as payroll, access to benefits packages, and workers' compensation and unemployment insurance claims.
18. After interviews were completed, state legislators in some study states, including Minnesota and Rhode Island, introduced legislation to further regulate the sale of stop-loss coverage to small employers. See 2013 MN HB 647 and 2013 RI HB 5459.

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Navigator and In-Person Assistance Programs: A Snapshot of State Programs

The Affordable Care Act (ACA) creates new opportunities for the states and the federal government to establish enrollment assistance programs to support the coverage expansions that are slated to take place in January 2014. Two of the new programs created through the ACA include Navigator programs that are required in every state Exchange as well as optional In-Person Assistance (IPA) programs that are intended to provide additional assistance options to states and to fill in the gaps in Navigator programs during the first open enrollment period. These Navigators and In-Person Assisters will provide outreach and education to consumers as well as direct assistance with submitting applications and enrolling into coverage. As we near the October 1st open enrollment deadline, state enrollment assistance programs are beginning to take shape.

Many of the 17 states and the District of Columbia that are running their own Exchanges are moving forward with establishing Navigator and IPA programs. Through policy documents and Requests for Proposals (RFPs) these states are articulating how these programs will be structured, who will be eligible to participate, what the roles and responsibilities and other participation requirements will be, and how these entities will be compensated and evaluated (Table 1). Although similar in many aspects, key differences are emerging across the programs reflecting the flexibility states have to tailor these programs to meet specific needs. This brief discusses some of the key policy decisions states are making and briefly describes these programs in a handful of states. This brief is not intended to offer comprehensive examination of all state activity, but rather provides a snapshot of key decisions in a few states. States were included in this snapshot if they had released a detailed RFP or other policy documents describing how these assistance programs would be structured.

Policy and Design Issues

Defining the roles of Navigators and IPAs. The roles and responsibilities of Navigators are defined in statute and regulation, and Navigators must meet those minimum requirements. Guidance provided to date on IPA programs suggests that these entities will perform the same or similar functions as Navigators; however, states will have some flexibility to define these roles. A number of states have chosen to define the roles similarly or the same. For example, Navigators and IPAs will perform the same roles in Arkansas, New York, and Washington. In other states, Navigators will conduct outreach and education as well as enrollment assistance, while IPAs will provide enrollment assistance only. This will be the case in California, Nevada, and Oregon. In Maryland, Navigators and IPAs will perform the same functions, except that only certified Navigators will be permitted to assist consumers with selecting a Qualified Health Plan (QHP) in the Exchange. This type of distinction in functions raises questions about how the state will ensure all consumers receive the full range of assistance they need. States granting more limited authority to IPAs will need to specify when and how hand-offs will occur between the IPAs and Navigators to ensure that consumers are able to complete the enrollment process.

States may also require these assisters to target different populations. In general, states specify that Navigators and IPAs must focus on potentially eligible populations, especially hard-to-reach and vulnerable populations. However, some states require either Navigators or IPAs to focus on different types of consumers. In Delaware, the state anticipates Navigators will focus on hard-to-reach populations while IPAs will serve a wider range of consumers. In Nevada, it is the IPAs who are required to target hard-to-reach populations, such as American Indians, rural residents, and those with limited English proficiency.

Training, certification, and licensing requirements. Adequate training will be essential to ensure Navigators and IPAs have the expertise they need to help consumers make informed coverage and enrollment decisions. Recently released proposed federal rules specify the training and certification requirements for Navigators in Partnership and Federally-facilitated Exchanges and for IPAs in Partnership Exchanges. These rules require 30 hours of training and certification after receiving a passing score on an HHS-approved exam. State-based Exchanges may adopt the federal standards or develop their own requirements that meet the federal standards. Many states do not specify the number of training hours that will be required, but of those that have, most are consistent with the federal standards. California will require completion of a 2-3 day training course and Connecticut will require a four-day training. Washington will require 40-50 hours of training, while Maryland mandates a more extensive 120 hours of training. Many states are also requiring Navigators and IPAs to pass background checks in order to receive certification due to the sensitive nature of the information assisters will collect from the consumers they help.

Some states also require Navigators and IPAs to be licensed in order to assist consumers with enrolling in QHPs. Nevada requires Navigators and IPAs to obtain an Exchange Enrollment Facilitator license or a Producer license to provide enrollment assistance. Maryland does not require Navigators to obtain a license to enroll consumers into QHPs; however, only certified Navigators can assist with enrollment in a QHP, and in certain circumstances, Navigators are required to refer consumers to brokers. In some cases, these licensing and other requirements are intended to limit the ability of Navigators and other assisters to perform, while in other cases, they reflect state goals of complying with longstanding laws governing agents and brokers. Proposed federal regulations state that any licensing or other requirements that impede Navigators from fulfilling the requirements specified by the ACA are preempted, though more specificity on the kinds of requirements that will be prohibited will likely be needed.

Compensating and assessing Navigator and IPA performance. Most states are using performance-based competitive grants to pay Navigators and IPAs, though some are considering per application payments for IPAs. Across most states, the performance metrics are based on enrollment targets that will be developed as part of the contracting process. Most states will be providing Navigator and IPAs with unique ID numbers as a way to monitor performance in meeting application and enrollment goals. Some states are also developing performance measures related to Navigator and IPA outreach and education activities. Arkansas, for example, will base payments to IPA Guides in part on meeting targets related to completed outreach and education activities.

California and Minnesota will compensate IPAs for each successful enrollment into a QHP. California will also provide payment for renewals and has set the payment rates at $58 for each successful new enrollment and $25 for each renewal.

Coordinating with other consumer assistance efforts. Another important consideration for states as they develop their programs is how Navigators and IPAs will interact with other entities providing consumer assistance, such as those providing outreach and enrollment assistance to Medicaid and CHIP beneficiaries and the staff of Exchange Call Centers, among others. Navigators and IPAs are expressly funded through Exchanges and federal Exchange grants. As such, these entities are primarily responsible for assisting consumers with enrollment into coverage through Exchanges. At the same, time they are required to maintain expertise in the eligibility and enrollment procedures for all insurance affordability programs, which include Medicaid and CHIP. States have the option of requiring Navigators and/or IPAs

to also provide outreach and enrollment assistance to consumers who may be eligible for Medicaid; however, they are not required to do so. Some states, such as Arkansas and Washington, include Medicaid enrollment targets in their performance metrics, assuring that assisters will focus on these populations as well as those eligible for enrollment into QHPs. Other states provide less guidance on whether or how coordination will occur.

Some states are developing comprehensive programs that include direct coordination with the Medicaid agency or are building on existing consumer outreach and assistance programs in Medicaid and CHIP. Cover Oregon, Oregon's Health Insurance Exchange, is partnering with the state's Medicaid agency to develop the Community Partners Program to provide outreach and application assistance for hard-to-reach and underserved populations. The program will include assisters funded through the Exchange as well as outreach workers and outstationed eligibility workers funded through Medicaid. In New York, the Navigator/IPA program is expected to replace an existing Facilitated Enrollment Program for Medicaid and CHIP, and the state specifically encourages entities participating in that program to apply to participate as Navigators/IPAs.

Funding Navigator and IPA programs. An important difference between Navigator and IPA programs is how they are funded. Navigator programs must be funded as part of Exchange operations, although planning and start-up costs can be financed through federal Exchange grants. IPA programs, in contrast, can be funded entirely through federal Exchange grants for the first year of Exchange operations. States appear to be setting aside varying amounts of funding for these programs, likely reflecting different assessments as to the need for direct enrollment assistance across states and possibly some uncertainty over how federal funding can be used to support these programs. Although California has not yet released the RFP for its Assisters program, the state has estimated it will need to contract with as many as 21,000 Individual Assisters to reach its target population. Maryland has allocated nearly $25 million ($8.8 million for Navigators and $16 million for IPAs) and Arkansas has set aside $17 million to finance over 500 IPA Guides during the first open enrollment period. Other states are envisioning much smaller programs. Nevada and Connecticut, for example, have allocated just over $2 million for their Navigator and IPA programs.

Looking Ahead

Providing enrollment assistance will be a key component of successful implementation of the coverage components of the ACA. This snapshot of state activity highlights the progress made to date in a number of states to develop Navigator and IPA programs that will provide direct enrollment assistance and also shows the variation in state approaches to developing these programs. It emphasizes the flexibility states have in designing their programs, but also underscores the difficult deadlines state face as they work to develop these programs and train and certify the individual assisters who will need to be in place before open enrollment for the Exchanges begins in October.

Table 1: Key Components of State Navigator and In-Person Assistance Programs, as of April 16, 2013

	Status	Program Model	Roles	Eligible Entities	Certification and Training	Compensation and Funding
AR	RFQ for IPA Guide Program issued on March 5, 2013; bids due beginning April 11, 2013	IPA Guide entities and IPA Guides will conduct targeted outreach and provide assistance to consumers with enrolling in private insurance and Medicaid through the Arkansas Partnership Exchange. The states estimates 535 IPA Guides will be needed during the initial open enrollment period.	IPA Guides will conduct targeted community outreach and education and enrollment assistance, with a special emphasis on vulnerable populations and others who may face barriers to receiving assistance.	Entities eligible to participate include those specified for Navigators in the final Exchange regulations issued by HHS (45 CFR 155.210). Agents and brokers can participate as IPA Guides but cannot receive compensation from insurers.	IPA Guides must complete training provided by the Arkansas Department of Insurance and must pass a background check.	IPA Entities compensated through a performance-based grant tied to attainment of 85% of agreed upon monthly goals. The state has allocated $17 million in funding for the first year of the program.
CA	IPA Program application release scheduled for early April 2013; Navigator program application release scheduled for June 2013	Assisters program, consisting of Navigators and In-Person Assisters, will engage organizations to help consumers learn about and apply for coverage. The state expects to contract with over 3,600 Assister Entities and over 21,000 Individual Assisters.	Navigators will provide outreach, education and enrollment assistance; IPAs will provide enrollment assistance only.	In addition to ACA required entities, other groups including attorneys, faith-based organizations, school districts, tax preparers, city government agencies, and county social services offices. Agents and brokers, County health departments, hospitals, and other providers may participate in the Assisters program but are not eligible for compensation.	Individuals must complete a 2-3 day instructor-led or computer-based training program. Upon completion of training and testing, Individual Assisters will be certified and receive a unique Assister number. A background check may be required for certification.	Navigators compensated through a performance-based block grant tied to grantees' Covered California QHP enrollment targets. IPAs will be compensated on a fee-for-enrollment basis-paid $58 per successful application and $25 per successful annual renewal. Program funding will be available for In-Person Assisters beginning before October 1, 2013 and for Navigators beginning December 2013.

	Status	Program Model	Roles	Eligible Entities	Certification and Training	Compensation and Funding
CO	RFP issued 2/22/13; applications due 4/19/13	"Connect for Health Assistance Network" combines Navigator and IPA programs into one. Exchange will contract with Assistance Sites, including 5 or 6 "regional hubs" that will receive enhanced awards and assume additional responsibility. Assistance Sites will hire Health Coverage Guides (individual assisters).	No distinction between Navigators and IPAs; "Health Coverage Guides" will perform all in-person assistance services, including educating consumers on health coverage options, assisting with application completion, and providing post-enrollment support.	Minimum eligibility requirements consistent with final Exchange regulations issued by HHS (45 CFR 155.210). Only organizations/entities may apply for funding; individuals ineligible to apply. Membership associations may apply on behalf of their members.	COHBE will certify Assistance Sites and develop training curriculum. Health Coverage Guides must complete COHBE Health Coverage Guide training program and receive assignment from a certified Assistance Site, including passing a background check and signing a security statement, to achieve certification.	Funding will begin July 1, 2013 and disbursements made monthly through December 31, 2014, provided that the grantee is making progress towards enrollment goals and adhering to reporting requirements. Program will be funded through federal and private grants in 2013 and 2014 and through private grants and COHBE operational revenue in 2015 and beyond.
CT	Navigator program design approved by Board of Directors 11/29/12	The Exchange is partnering with the Office of the Healthcare Advocate to administer the Navigator and In Person Assistance Programs (NIPA). The Exchange estimates 91 IPAs will be needed during the open enrollment period.	Navigators will specialize in educating and enrolling underserved populations; IPAs will enhance existing networks that provide eligibility/enrollment assistance, like FQHC providers and the Department of Social Services.	Eligible entities include those specified in the final Exchange regulations issued by HHS (45 CFR 155.210). Agents and brokers can participate as Navigators/IPAs but cannot receive compensation from insurers.	Navigators must complete a 4-day in-person training, score 80% or better on a certification test, and pass a background check. The annual recertification process consists of 15 hours of training and a test.	Navigators compensated through a performance-based grant tied to meeting pre-established metrics. The Exchange has designated $500,000+ in Navigator grants per fiscal year. Exchange was awarded $2.1 million grant from HHS to establish IPA program.
DE	RFP issued 2/5/13; applications were due 3/6/13	Marketplace Assister entities will be managed by the Department of Insurance Consumer Services Division and the Division of Medicaid and Medical Assistance. Marketplace Assister entities will hire, train, and monitor individual Marketplace Assisters (MPAs).	MPAs and Navigators will provide the same general services, including conducting outreach, educating consumers about the Exchange and enrollment requirements, and assisting with application completion and coverage renewal. Navigators will target hard-to-reach populations, while MPAs will serve a wider range of consumers.	Any entity with a valid Delaware Business License is eligible to apply, with the exception of health insurance carriers, their subsidiaries, and any association that lobbies on behalf of the insurance industry.	MPAs must complete a training program, provide three letters of reference from members of the community, pass a background check, and agree to a number of ethical and conflict of interest standards to become certified.	Marketplace Assister entities will compensate individual MPAs using grant funding.

	Status	Program Model	Roles	Eligible Entities	Certification and Training	Compensation and Funding
MD	Grant solicitation for connector entities released 1/17/13; applications were due 2/28/13	Regional "Connector Entities," with one entity in each of six regions, will provide services through Individual Exchange Navigators, Assisters, and possibly SHOP Exchange Navigators. MHBE will supplement regional entities with state-wide services, such as sign language interpreters, a 24/7 language line, and TTY/TTD capabilities.	Navigators and Assisters will provide ongoing support with outreach and education, eligibility determinations, and enrollment in Medicaid and CHIP. Only certified Navigators may facilitate enrollment in a QHP.	Eligible entities include those specified in the final Exchange regulations issued by HHS (45 CFR 155.210). Authorized producers will not participate as Navigators, but are permitted to sell on both the Individual and SHOP Exchanges.	Navigators must complete a training program, expected to take 120 hours, and pass a final exam to receive certification. Navigators can choose to become licensed SHOP Navigators. Assisters will receive more limited training (20-60 hours) and will not be certified.	Each connector entity will be eligible for a maximum grant award, contingent upon meeting requirements and performance targets. Connector entities will also be eligible for a performance-based bonus based on new enrollment in the region. MHBE estimates $8.8 M in operating funds to support Navigators, and $16 M in federal grant funds to support Assisters, program start-up, and other functions in 2013.
MN	Proposed rules for entities delivering consumer assistance issued on April 1, 2013; comments are due April 21, 2013	Consumer assistance partners, including Navigators, In-Person Assisters, and Certified Application Counselors, along with Producers will work together to facilitate enrollment of eligible individuals into coverage.	Consumer assistance partners will guide consumers through the application and enrollment process and facilitate access to the range of health coverage options available through MNsure. However, consumers needing additional QHP enrollment assistance must be referred to a Producer.	Eligible entities include those specified in the final Exchange regulations issued by HHS (45 CFR 155.210).	Consumer assistance partners must complete a web-based training program, pass a certification exam, and comply with conflict of interest and privacy and security standards.	IPAs will be eligible to receive infrastructure and outreach grants and will receive payment for each successful enrollment into a QHP. Certified Application Counselors will not receive payment from the Exchange.

	Status	Program Model	Roles	Eligible Entities	Certification and Training	Compensation and Funding
NV	RFA for Navigators and Enrollment Assisters released on March 1, 2013; applications were due April 4, 2013	Navigators, Enrollment Assisters, Certified Application Counselors, and Producers will work together to facilitate enrollment of eligible individuals into coverage.	Navigators will provide outreach, education and enrollment assistance; Enrollment Assisters will provide enrollment assistance only with a focus on hard-to-reach populations.	Eligible entities include those specified in the final Exchange regulations issued by HHS (45 CFR 155.210).	Navigators must complete training provided by the Department of Insurance based on model federal standards and pass a certification exam. Navigators and Enrollment Assisters must obtain an Exchange Enrollment Facilitator (EEF) license or a Producer license in order to enroll eligible individuals and employers into QHPs.	Navigators and Enrollment Assisters will be compensated through a competitive grant process awarded in a block amount and paid on a reimbursement basis. The state has allocated funding of $370,000 for SFY 2014 for the Navigator program and $1,826,000 for SFY 2014 for Enrollment Assisters.
NY	RFA issued 2/13/13; applications due 4/8/13	Exchange will contract with IPA/Navigator entities and Lead Organizations that subcontract with one or more organizations; entities may apply to serve a single or multiple counties/boroughs.	Navigators and IPAs will provide the same services, including educating consumers on health plans available to them, assisting with application completion, and providing renewal assistance.	Eligible entities include those specified in the final Exchange regulations issued by HHS (45 CFR 155.210). Health care providers may participate if they meet certain requirements. Local Social Service Departments are ineligible. Producers may participate as IPA/Navigators but cannot receive compensation from insurers.	The Department of Health and its training contractor will finalize the IPA/Navigator program training curriculum by April 2013. IPAs and Navigators must complete training and receive certification prior to providing services.	Maximum annual award for entities dependent on county/borough. DOH plans to make a total of $27.2 million/year available to IPA/Navigator entities for five years.

	Status	Program Model	Roles	Eligible Entities	Certification and Training	Compensation and Funding
OR	RFP for community partners released April 11, 2013; grantees to be announced in July 2013	Exchange will partner with OHA to expand OHA's existing outreach and application assistance program. The state will use community partners, which are local organizations that are cultural experts on their community. Staff at these organizations will be known as application assisters.	Oregon uses the term "application assister" to encompass Navigators, IPAs, and application counselors. Application assisters will conduct eligibility and enrollment for public and private health coverage. Application assisters may help consumers with enrolling in a QHP; however, if consumers need information on QHPs beyond what is available through the website, assisters must refer the consumers to an agent.	The assisters program will build on an existing network of providers who offer enrollment assistance in public programs. Agents and brokers will not participate as Navigators, but will be involved in a separate Agent Management program.	Training and certification is required for all application assisters, including paid staff and volunteers, and must be renewed annually. In-person and web-based training will be provided free of charge. Application assisters must pass a background check and will receive an identification number.	Community partners will be eligible to receive performance-based grants, though funding will not be available to support all community partners. Community partners not receiving a grant will be permitted to provide application assistance as long as they sign an agreement with OHA.
WA	RFP for IPA Lead Orgs issued 3/8/13; applications due 4/22/13. Tribal RFP released 4/5/13; applications due 6/28/13.	Lead Organizations (organized by county service areas or targeted populations) will contract with the Exchange and will be responsible for building, training, funding, and monitoring local Navigator networks comprised of IPA organizations and individual IPAs. An estimated 170 assisters working 6 hours/day will be needed for the initial open enrollment period.	Navigators and IPAs will perform the same services, including providing enrollment assistance to consumers maintaining ongoing relationships with consumers. Lead Organizations may elect to utilize some Navigators/IPAs for community outreach and awareness only. IPAs will be phased out of the Navigator program in 2015.	Eligible entities include those specified in the final Exchange regulations issued by HHS (45 CFR 155.210). Agents/brokers are not expected to participate in the Navigator program but will collaborate with Navigator/IPAs. The Exchange is currently developing a business model for agents/brokers.	The Exchange will develop training materials and train designated staff at Lead Organizations who will educate Navigators/IPAs in their networks. Individuals will be required to complete 40-50 hours of training, pass a certification examination, acknowledge a Code of Ethics, and have a background check on file to be certified. Assisters require certification only if they are designated to provide application-through-enrollment services.	Allocation of funding will be determined geographically, using a needs-based index. Lead organizations compensated through performance-based grants, with 50% of compensation tied to meeting established enrollment goals. Lead Organizations will adopt a similar approach to compensating entities in their networks. The Exchange has allocated $6 million for IPA Lead Organization contracts from a federal exchange establishment grant.

Source: KFF review and analysis of state policy documents and Requests for Proposals (RFPs).

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Strengthening Affordability and Quality in America's Health Care System

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Introduction

Background

The U.S. health care system plays a vital role in the health of our nation's people and economy. We invest trillions of dollars in health care each year, yet miss significant opportunities to reap the value of our investment because the system was not designed to consistently reward high-quality care provided at an affordable cost. It therefore wastes limited resources without producing outcomes that support a healthy society.

We believe we can do better.

Our group of diverse health care stakeholders came together over the past year to develop a road map to transform the health care system by improving efficiency, clinical effectiveness, and value for patients. We represent stakeholders in the hospital, business, consumer, and insurance sectors: Ascension Health, the Pacific Business Group on Health, Families USA, the National Coalition on Health Care, and America's Health Insurance Plans (AHIP). The American College of Surgeons (ACS) also joined in the discussion of key principles consistent with the ACS commitment to inspiring quality, clinical registries, and reforming payment. We are committed to continuing to work collaboratively to advance these recommendations.

While representing diverse constituencies and perspectives, we strongly believe that unsustainable increases in health care spending urgently call for integrated, system-wide reforms that generate better value. We share a common vision, embrace core principles, and support key changes that are necessary to achieve the transformation we are recommending.

The importance of bringing growth in health care costs under control cannot be overstated. While the U.S. health care system has many positive attributes, the system as a whole is costly, especially when compared to other industrialized countries. Although health care spending in recent years has grown more slowly than historical rates would have predicted, forecasts suggest that the nation's health care budget will still grow at an unsustainable pace—far faster than the general economy—in the coming decades.[1] Given that the fundamental drivers of health care spending have not been altered, a return to such unprecedented levels of spending is likely in future years unless we take steps to manage costs.

Our Vision

We envision a high-performing, accountable, coordinated health care system where patient experience and population health are improved, and where per-capita health care spending is reduced.

The specific elements of our vision are as follows:

- Health care that is affordable and financially sustainable for consumers, purchasers, and taxpayers.
- Patients who are informed, empowered, and engaged in their care.
- Patient care that is evidence-based and safe.
- A delivery system that is accountable for health outcomes and resource use.
- An environment that fosters a culture of continuous improvement and learning.
- Innovations that are evaluated for effectiveness before being widely and rapidly adopted.
- Reliable information that can be used to monitor quality, cost, and population health.

Our Principles

Our vision is supported by a set of core principles. We constructed and organized our recommendations in accordance with these principles:

- The delivery and payment system must be fundamentally transformed. Incremental changes will not provide the comprehensive transformation needed to improve quality of care and control growth in health care spending.
- Health-related measures to reduce the federal budget deficit should be consistent with, and should move us toward, our goal of sustainable, system-wide improvement.
- Incentives for providers, payers, employers, and consumers must be aligned to ensure that they improve health and promote the use of effective, appropriate services.
- The best way to drive innovation and improvement is through healthy competition based on cost, patient experience, and health outcomes, with government as an important partner in this effort.
- Merely shifting costs from one party to another is not true cost control. We endorse policies that will bring total costs under control.
- Vulnerable populations should be protected as we design and implement the difficult policy reforms needed to control growth in health care spending.

Our Recommendations

The following five recommendations represent integrated, system-wide reforms that are needed to address the challenges America faces. The first three recommendations align incentives to transform the way providers deliver—and how consumers and payers demand—high-quality, well-coordinated care. The latter recommendations strengthen the infrastructure needed to achieve desired results in the form of savings and better health outcomes and provide important incentives for states to work in innovative partnerships with public and private stakeholders to truly transform the health care system.

1. **Transform the Current Payment Paradigm.**
   We believe that transitioning away from the current fee-for-service payment system is the key to achieving high-quality, affordable care. We have been encouraged that, over the past few months, other organizations are also embracing this concept of "fundamental change." We believe these statements of support are important indicators that the nation can increase value in health care and that the public and private sectors can work together to achieve it. Over the next five years, we encourage accelerated adoption of payment approaches that demonstrate their effectiveness in improving both quality and cost. These value-based payment approaches include a range of models that include incentives for patient safety, bundled payments, accountable care organizations, and global payments. We support the ongoing national dialogue regarding the setting of ambitious but achievable payment reform targets and recommend that valid and reliable metrics be developed to track the nation's progress in moving payment reform forward.

2. **Pay for Care that Is Proven to Work.**
   To the extent that we continue paying for specific health services under a fee-for-service payment structure, public programs and the private sector should reduce payments for services that prove to be less effective and to have less value than alternative therapies. The failure of the current system to make such differential payments results in the overuse of ineffective, costly services and the underuse of services that provide proven clinical benefits and high value.

3. **Incentivize Consumer Engagement in Care.**
   When designing consumers' cost-sharing, differentiation to encourage the use of high-value services and providers should be used—without creating barriers to the appropriate utilization of services for any populations, paying special attention to the needs of low-income and other vulnerable populations. The goal of such tiered cost-sharing is to create financial incentives for consumers to make better use of their discretionary care choices, leading to savings from improved adherence to preventive measures and evidence-based care; lower utilization of unnecessary services; and the use of more efficient, higher-quality providers.

4. **Improve the Infrastructure Needed for an Effective Health Care Market.**
   We need to strengthen and simplify the foundational infrastructure of America's health care system so that the cost- and quality-related innovations described above can work. This should include (1) accelerating research on treatment effectiveness to give patients and providers more information on which to base health care decisions; (2) priortize the development and adoption of uniform measures and advance electronic data collection to support reporting; (3) ensuring that there is an adequate and diverse health workforce to provide coordinated care; (4) streamlining administrative processes to reduce waste; (5) reducing and resolving medical malpractice disputes by adopting innovative approaches, including those that promote patient-provider communication; (6) promoting efforts to increase the transparency of health care information, including consumers' out-of-pocket costs; and (7) encouraging competitive markets.

5. **Incentivize States to Partner with Public and Private Stakeholders to Transform the Health Care System.**
   For states that bring stakeholders together to develop innovative reforms that lower the growth of total health care spending throughout the public and private sectors, we propose a gain-sharing system that would enable those states to receive fiscal rewards for successfully meeting cost- and quality-related goals. States could use different combinations of strategies that fit their specific cultures and political environments, ranging from working with private and public payers to collaboratively implement major payment reforms, to modifying scope of practice restrictions, to providing incentives for improvements in care coordination to promote quality and patient safety.

Our organizations are committed to working together, and with others in the private and public sectors, to achieve these objectives. The consensus recommendations set forth below are unique, but not simply because of the diversity of the organizations that developed them.

The proposals in this document present a roadmap for structural reform that will bend the overall cost curve. Our recommendations are not aimed at individual public or private programs—they are instead an integrated construct designed to promote reform. They are also designed to prevent the traditional shifting of costs from one payer to another. Our goal is to present action steps that will be undertaken in the federal, state, and private sectors to make the entire health care system safer, more affordable, and more effective, resulting in system-wide reform that will yield substantial cost savings over time.

1 Transform the Current Payment Paradigm

The Problem: Why We Need Comprehensive Payment Reform

While the United States invests billions of dollars annually to support a high-performing health care system, the system fails to consistently deliver value when it comes to cost, quality, and health outcomes. Traditional payment models exacerbate these problems, as providers are often paid based on the volume of services they perform, as opposed to whether they deliver the right care at the right time.

There are no system-wide incentives to maintain an appropriate level of spending, which results in cost shifting from one sector to another while overall costs continue to rise. Consumers lack both the information they need to make informed choices and meaningful incentives that would induce them to select higher-quality and lower-cost services, drugs, and providers. Medicare's physician payment structure fails to promote improvement in health outcomes or innovation in care delivery.

To facilitate the transformation of our delivery system into one that rewards quality and efficiency, the payment system will need to be fundamentally changed in terms of what it pays and how it pays. We believe that the government and private sector must work together to create the right incentives and ensure that the right information is in place to support efficiently, effectively delivered high-quality health care services. We support comprehensive payment and delivery reforms in both the public and private sectors, with the goal of transforming our current volume-based payment system to one that rewards health professionals and organizations when they achieve better patient outcomes, better health care, and lower costs.

Because this type of change must be system wide, it will take leadership and collaboration from a range of private- and public-sector leaders. However, since Medicare is the largest payer for care, and since other payers often use its payment approaches as a model, federal policy leadership—and a rapid transition of most Medicare payments to a value-based payment model—is essential to making these changes nationally.

The Department of Health and Human Services (HHS) and Medicare have a number of existing authorities to test and (after some time) expand certain payment innovations. However, relying solely on these authorities may ultimately prove inadequate to the task of transforming our health care system. To expedite the implementation and adoption of alternative payment models that result in improvements in both quality and efficiency in Medicare, Congress should grant HHS additional authority to make needed changes to payment policies in a timely manner.

Action 1: Promote the dissemination and implementation of alternative payment and delivery models that demonstrate success in improving quality and efficiency over the next five years.

There is broad agreement that payment reform is needed to reduce unnecessary health care expenditures and to foster practice redesign and quality improvements. We expect federal programs to use their purchasing power to accelerate the transition to value-based payment, in collaboration with private payers and purchasers. We recognize, however, that physicians and hospitals vary widely in

terms of readiness when it comes to changing how care is delivered and paid for and that the methods for changing payment systems must address this variation in capabilities. For that reason, we propose setting a clear direction for the public and private sectors but leaving the specific deployment and pacing of payment changes flexible.

A variety of models will help accelerate the shift to value-based payment and can be applied to specific patient populations and care settings. Collectively, these models have the potential to shift provider behavior toward a focus on patient health outcomes, care coordination, and the management of chronic conditions in appropriate settings.

Both public and private payers have already introduced payment models that promote better quality and care coordination and lower costs. Private payers are using medical homes that involve payments for care coordination, bundled payments for selected inpatient procedures, and the development of accountable care organizations (ACOs).[2] Public programs are also testing promising alternative payment methodologies through demonstrations under the Center for Medicare and Medicaid Innovation (CMMI), the Medicare Shared Savings Program,[3] the Pioneer ACO Model,[4] the Medicare hospital value-based purchasing model,[5] and value-based modifier physician payment[6] programs.

While system-wide change is essential, we believe that a one-size-fits-all approach should not be the objective, given the complexity of practice settings, varying levels of provider readiness, and the different needs of patient populations. Rather, having multiple approaches allows providers and health systems to build on the model that works best for them and their populations. To the extent that these models demonstrate improved quality and efficiency, they should be expanded as quickly as possible. Collaborations among Medicare and private payers on similar payment model constructs will enable more rapid adoption, since there needs to be a critical mass of patients and revenue that are affected by new payment arrangements to drive change at the provider level. Additionally, as these new models begin to take root, competitive pressure in the market can help accelerate adoption of new payment models and, ultimately, move the health care system closer to achieving the three-part aim (improved patient experience of care, improved population health, and reduced per-capita health care spending).

Finally, we must develop robust metrics that are designed to gauge progress in achieving the goal of transitioning public and private health care payments to value-based models over the next five years. Though still in the early stages, one such example that is currently emerging in the market is a set of metrics being developed by Catalyst for Payment Reform to assess progress in payment reform across markets.[7]

Payment model approaches and opportunities for expansion (contingent upon demonstrated improvements in quality and efficiency) include the following:

Incentives for Providers that Improve Patient Safety

Providing incentives to physicians and hospitals for meeting performance benchmarks compared to their peers, while accounting for case mix and socioeconomic status of their underlying populations, and not paying for hospitals' avoidable readmissions and preventable adverse events (such as wrong site surgery and hospital-acquired pneumonia).

- While private payers and Medicare are currently using these approaches, they must be accelerated to include other areas of preventable adverse events and must include benchmarks that continually drive improvement. Quality metrics should be aligned across both private and public payers, updated on a regular basis, and retired when they are no longer useful or when they have been universally achieved.
- Disseminating information on best practices in both the public and private sectors results in lower hospital readmission rates. These best practices include using financial incentives to reduce readmissions, promote case management, and establish Centers of Excellence.

Incentives for Providers that Improve Patient Safety

Efforts are currently underway in both the public and private sectors to provide support and incentives that are designed to improve patient safety. In the private sector, health plans have been collaborating with their network hospitals and state patient safety boards in the area of patient safety.[8] Plans use a variety of approaches, including promoting evidence-based care, toolkits that incorporate standardized processes to prevent infections, training hospitals on error-reduction strategies, changing payment models, tracking and reporting hospital and physician infection rates, and reporting those infection rates internally and publicly. Health plans use nationally recognized patient safety indicators for "never events," serious reportable events, surgical safety indicators, and preventable medial errors, specifically those from the Centers for Medicare and Medicaid (CMS), the National Quality Forum, Leapfrog, and the Joint Commission, among others. Health plan network hospitals that are participating in such improvement programs or activities have reduced their rates of infections and other safety events. For example:

- Blue Cross Blue Shield of Michigan's efforts to improve patient safety and reduce health care-acquired infections resulted in a 70 percent reduction in the rate of ventilator-associated pneumonia from 2008 to 2010, as well as a reduction from 19 percent to 14 percent in the rate of catheter use from 2007 to 2010 (among hospitals using evidence-based procedures to reduce catheter-associated urinary tract infections).[9]
- Kaiser Permanente's use of evidence-based care and toolkits to prevent infections has yielded the following results: In eight of Kaiser hospitals' adult intensive care units (ICUs), there has not been a single bloodstream infection in more than a year, and there have been no bloodstream infections in more than two years in two of Kaiser hospitals' adult ICUs.[10]

In 2011, the Centers for Medicare and Medicaid Services (CMS) began a public-private initiative called the Partnership for Patients. CMS awarded federal funding to 26 Hospital Engagement Networks (HENs) to engage and educate hospitals nationwide to improve patient safety. The partnership is focused on making hospital care safer by reducing preventable hospital-acquired conditions by 40 percent and reducing hospital readmissions by 20 percent by the end of 2013.[11] Individual HENs can select which of the following nine quality measures they will focus on: adverse drug events, catheter-associated urinary tract infections, central line-associated bloodstream infections, injuries from falls and immobility, obstetrical adverse events, pressure ulcers, surgical site infections, venous thromboembolism, and ventilator-assisted pneumonia.

Ascension Health was one of only five health care systems that were awarded a HEN contract. Ascension Health chose to focus on all nine of the quality measures listed above, in addition to reducing hospital readmissions. In its role as a HEN contractor, Ascension Health devised a system-wide Early Elective Delivery (EED) protocol and began implementation on March 1, 2012. An early elective delivery is an early birth that is scheduled without a medical reason, and these deliveries are associated with an increased risk of maternal and neonatal morbidity and longer hospital stays for mothers and their newborns.[12]

Because of past work in this area, Ascension Health already had an EED rate of 3.60 percent, well below the nationwide average of 10-15 percent. Over the past 12 months, Ascension Health further reduced its system-wide EED rate by 79 percent. This EED reduction is projected to decrease EED NICU admissions by 82 percent, generating a savings of more than $3.2 million in hospital and physician costs. Thirty-five hospitals achieved an EED rate of 0 percent.[13]

Patient-Centered Medical Homes

Expanding the use of payment models, such as those that are currently used in patient-centered medical home (PCMH) pilots, to include more patients and providers.

- To date, all 50 states have some form of a PCMH model or contract in place. Health plans and health systems in the private sector are implementing models of varying sizes, and programs are also being promoted within public health insurance programs such as Medicare and Medicaid. While individual models may vary with regard to contracted payment levels, most contain similar components: a base pay, a per-member per-month (PMPM) fee for care coordination/transition, and incentives to reach or exceed agreed-upon quality benchmarks.[14]
- Multi-payer medical home initiatives similar to the successful multi-payer PCMH pilot in Colorado[15] and other initiatives launched by the CMS Innovation Center, such as the Comprehensive Primary Care Initiative[16] and the Advanced Multi-payer Primary Care Demonstration,[17] should be expanded to other locations across the country as soon and as widely as practicable.
- Over time, the proportion of medical home payments that are contingent on achieving quality and cost goals should increase. Some practices may ultimately move to a model that provides a single capitated payment for a patient's primary care.

What the Evidence Shows

Patient-Centered Medical Homes

Numerous studies have found evidence of cost savings and quality improvements resulting from the implementation of medical home programs. While the magnitude of savings varies depending on a range of factors, including program design, enrollment, payer, target population, and implementation phase, substantial savings have been demonstrated across a wide range of medical home programs. Examples include the following:

- Geisinger's Proven-Health Navigator Model, which serves Medicare patients in rural northeastern and central Pennsylvania, found 7.1 percent savings over expected costs.[18]
- Evidence from the Genesee Health Plan in Flint, Michigan, indicates that increasing access to primary care services and using health navigators to help patients adopt healthy behaviors and manage chronic diseases reduced enrollee use of emergency department services by 51 percent between 2004 and 2007 and reduced hospital admissions by 15 percent between 2006 and 2007.[19]
- Community Care of North Carolina's Medicaid managed care medical home program found an average of $25.40 in savings per member, per month (PMPM) (5.8 percent savings over expected costs). The program saw substantially higher savings within the non-aged, blind, or disabled child and adult Medicaid populations ($32.94 and $77.56 PMPM, respectively).[20]
- One study found that that WellPoint's medical home model in New York yielded risk-adjusted total PMPM costs that were 14.5 percent lower for adults and 8.6 percent lower for children enrolled in a medical home.[21]
- Preliminary results from CareFirst Blue Cross Blue Shield's medical home program showed an estimated 1.5 percent savings in its first year of operation, before accounting for provider bonuses. While formal evaluations are ongoing, CareFirst anticipates that savings levels may reach 3 to 5 percent in future years.[22]
- Similar levels of savings have been found in medical home models that include a mix of public and private payers. For example, UPMC's multi-state medical home pilot, which includes a mix of commercial, Medicaid, Medicare, and dually eligible patients, showed a net savings of $9.75 PMPM for individuals enrolled in the medical home pilot.[23]

Bundled Payments

Adopting bundled payments for select conditions and procedures that encompass a set of well-defined services and have a relatively clear beginning and end point.

- Medicare pilots that use bundled payments for acute hospitalization and post-hospitalization services should be broadly implemented across Medicare, with further expansion of these bundles through collaboration and alignment with the private sector.
    - For example, over time, Medicare and other payers should expand bundled payment initiatives beyond inpatient hospital and physician services, to include, where appropriate, post-acute care, follow-up physician services, and readmissions within a defined period following discharge (for example, 30/60/90 days).
    - Medicare and other payers should build on the experience of Medicare's Acute Care Episode (ACE) Demonstration,[24] which has yielded lower costs and higher quality by bundling payments for certain cardiac and orthopedic procedures at selected hospitals in five states. Following the success of the CMS Acute Care Episode Demonstration, CMMI has developed the Bundled Payments for Care Improvement (BPCI) Initiative, which aims to reimburse health care providers with a bundled payment based on the expected costs for a specific diagnosis-related group (DRG), with the expectation that high-quality care will still be delivered.[25] The ACE Demonstration and other bundling initiatives that produce cost savings and comparable- or better-quality care should be more broadly implemented across Medicare and the private sector.
- Private-sector bundled payment initiatives have addressed specific procedures as well as defined episodes of care and have shown both cost savings and quality improvements. The Prometheus Payment Project is an example of a private-sector model that bundles payments around a comprehensive episode of care that covers all patient services related to a single illness or condition, based on evidence-based care guidelines. Broader adoption of procedure and episode-based models, drawing on common elements across Medicare and private-sector bundling initiatives, should be encouraged.
- Payers should jointly develop and test episode-based payments for high-prevalence, high-cost conditions to be used across payers. This will require the use of common definitions and agreement on the services to be included in the episode-based payments. Similarly, condition-specific, episode-based payments must be explicit about which services and treatments are included and excluded from the bundled payment. In proceeding with the implementation of episodic bundling, it will be vital to continuously improve quality metrics and strengthen the link between the payment bundle and performance on those quality metrics.

Bundled Payments

Research has shown that bundled payments can align incentives for hospitals, post-acute care providers, doctors, and other practitioners to partner closely across all specialties and settings that a patient may encounter. The potential for savings under a bundled payment model is largely driven by the wide variation of costs for given episodes of care within the current fee-for-service payment system. By incentivizing providers to improve efficiency and reduce this variation in spending, bundling payments could significantly reduce overall costs. For example, a study by Miller and colleagues found that current Medicare payments for certain inpatient procedures varied by 49 to 103 percent and concluded that bundling payments could "yield sizeable savings for payers."[26] Estimates of savings from bundling payments include the following:

- Recent modeling of the Medicare program estimated that reducing variations in payment for 17 specific episodes of care to the 25th percentile of payment would save $10 billion annually. If reimbursements for the same bundles were set at the 50th percentile, annual savings of $4.7 billion would be generated.[27]
- A 2008 analysis conducted by the Congressional Budget Office estimated that bundling hospital and post-acute care for the Medicare population would save $19 billion over a 10-year budget window in which bundles were implemented beginning in the fourth year and reaching full implementation in the sixth year.[28]
- Evidence from Medicare's Participating Heart Bypass Center demonstration project indicates that Medicare saved approximately 10 percent on coronary artery bypass graft (CABG) surgery within the demonstration population.[29] In addition, participating hospitals experienced a cost reduction of 2 to 23 percent by changing physician care practices and hospital processes.[30]
- The Medicare Acute Care Episode (ACE) demonstration project bundled payment for all Medicare Part A and Part B services that were provided during acute care hospitalizations for specified cardiovascular and orthopedic procedures. Participating hospitals, physicians, beneficiaries, and Medicare itself all gained through the ACE demonstration. Not only did Medicare reduce payments within the demonstration, but, for example, Baptist Health System, one of the participating hospitals, saved $2,000 per case. In addition, it received approximately $280 in gain-sharing payments per episode. And each participating beneficiary saved approximately $320 in the form of reduced Part B premiums.[31]
- Similar positive outcomes have also been demonstrated in testing in the private market. For example, Geisinger Health System's ProvenCare model, which bundled payments for non-emergency CABG surgery, yielded not only hospital savings that averaged 5 percent, but it also reduced readmission rates, infection rates, and hospital mortality rates.[32]
- Innovation in the area of bundling continues to occur, with new initiatives like UnitedHealthcare's Cancer Care Payment Model. In 2010, UnitedHealthcare partnered with five medical oncology groups to test a new payment model for patients with breast, colon, and lung cancers. This outpatient program reimburses physicians upfront for the entire cancer treatment program of six to 12 months, with bundled payments renewed every four months thereafter as necessary.[33]

Accountable Care Organizations (ACOs)

Expanding the use of accountable care organizations, which are responsible for improving the quality and lowering the cost of care in exchange for a share of savings if they meet quality and cost goals, including a shift toward shared risk model ACOs, with the collaboration of the private sector.

- Medicare's Shared Savings Program now includes 220 ACOs, an increase of 106 organizations from the initial 114 applications.[34] An additional 32 ACOs are participating in Medicare's Pioneer ACO program, which puts providers on a faster track toward a population-based or shared-risk payment model.[35]
  - Over time, early accountable care models (like the Medicare Shared Savings Program) that have successfully reduced costs and improved care should transition to prospective global payments.
- ACOs are also proliferating in the private market. The Brookings-Dartmouth ACO pilots, as well as countless additional collaborations among insurers and providers, continue to develop and mature. For example, one national plan currently has more than 50 collaborative accountable care initiatives in 22 states encompassing nearly 510,000 members. The plan's goal is to have 100 such initiatives reaching 1 million members by the end of 2014.[36]
  - Early lessons from private-sector experience with ACO models highlight the importance of maintaining flexibility in any arrangements designed to effectively manage population health that are tailored to provider readiness and data-sharing capability. These early lessons should inform future development of ACO models to the extent that this model continues to evolve in both the public and private sectors.

What the Evidence Shows

Accountable Care Organizations (ACOs)

Whether in the public or private sector, the goal of the accountable care organization model is to incentivize doctors, hospitals, and other health care providers to deliver the right care at the right time in the right setting, thus lowering costs while increasing quality and improving patient outcomes. While most ACOs are in the nascent stage, preliminary findings from early adopters have affirmed that cost savings and quality improvements can both be achieved. Moreover, the Centers for Medicare and Medicaid Services (CMS) has estimated that the Medicare Shared Savings Program alone will generate $510 million in net federal savings between 2012 and 2014.[37] Other examples include the following:

- Findings from Aetna's Medicare Advantage partnership with the NovaHealth Physician Association in Maine (a model similar to the Medicare Shared Savings Model) demonstrate PMPM savings that have increased substantially over the course of the program, growing from $33.77 PMPM in 2009 to $73.91 PMPM in 2011.[38] Results also show lower acute admission rates, fewer acute days, fewer ED visits, and better clinical quality results.[39]
- In the commercial market, Cigna launched a Collaborative ACO model in 2008 in Arizona, New Hampshire, and Texas. Savings were generated in each of the three test markets, ranging from $27.04 PMPM in Arizona to $1.78 PMPM in New Hampshire.[40]
- Evidence from two additional commercial ACO programs, BlueCross BlueShield of Illinois' partnership with Advocate Health Care and Blue Shield of California's partnership with Catholic Health Care West (now Dignity Health), Hill Physicians Medical Group, and California Public Employees' Retirement System (CalPERS), demonstrate savings of 2 to 3 percentage points PMPM.[41]

- BlueCross BlueShield of Massachusetts' Alternative Quality Contract program, which creates a global budget for provider groups and allows them to earn bonuses of up to 10 percent of their global budget, has shown savings of 2.8 percent PMPM compared with spending observed in non-participating groups.[42]
- Arizona's Mercy Care Plan for beneficiaries who are dually eligible for Medicare and Medicaid has had great success in improving care for this vulnerable population using a patient-centered model focused on care coordination. Evidence suggests that, when adjusted to match the health risks of those dually eligible individuals enrolled in fee-for-service plans, Mercy Care enrollees spent 43 percent fewer days in the hospital, experienced 21 percent fewer hospital readmissions, and made 9 percent fewer emergency department visits.[43]
- Genesys HealthWorks is a model of care developed by Genesys Health System (sponsored by Ascension Health) in Flint, Michigan, to improve population health and the patient experience of care while reducing or controlling increases in the per capita cost of care. Among patients who receive care through Genesys Health System and its affiliated physicians, the model has helped lower the use and cost of care while improving physician performance on quality indicators. An analysis sponsored by General Motors (GM) and the United Auto Workers (UAW) and conducted by Thompson Reuters found the automaker spent 26 percent less on health care for enrollees who received services at Genesys versus local competitors.[44]

Global Payments

Implementing global payments with full performance risk arrangements, including tested performance measurement and incentive programs, to dramatically improve quality and efficiency of care delivery. Under these arrangements, insurance risk is still retained by payers, and, in some instances, provider sponsored organizations (PSO) accept risk under these arrangements in compliance with applicable laws.

- Disseminating best practices for global payment models, including those from Medicare Advantage and Medicaid managed care, to further support movement to global payments, including alignment of quality measures across the public and private sectors.
- The Alternative Quality Contract that is used in Massachusetts has resulted in increased savings and quality over a two-year period for participating physician groups compared to their nonparticipating peers.[45]

What the Evidence Shows

Global Payments

While most formal evaluations of global payment or capitation models were conducted in the late 1980s or early 1990s, a few more recent publications have evaluated such models and found that they generate cost savings. Most of these more recent analyses are focused on ACO delivery models paired with a global payment structure and do not isolate the effects of ACO savings from savings generated by the global payments. Findings include the following:

- Evidence from BlueShield of California's ACO partnership with Catholic Health Care West (now Dignity Health), Hill Physicians Medical Group, and CalPERS, which puts a global budget for expected spending in place and shares risks and savings among partners, demonstrated savings of 2 to 3 percentage points PMPM.[46]
- Two separate analyses of BlueCross BlueShield of Massachusetts' Alternative Quality Contract showed savings of 2.8 percent PMPM across participating providers.[47]
- HealthCare Partners, one of four ACO provider groups within the Brookings-Dartmouth ACO pilot, plans to phase in a global capitation model over the next five years with a projected potential savings of 3 to 7 percent.[48]

Medicare Provider Payment Reform

Medicare is the nation's largest payer for health care services, and the reimbursement approaches of other public and private payers often draw on or build on Medicare's methodology. For these reasons, real transformation of payment and delivery across payers and settings of care will require reforming how Medicare pays physicians and other health care providers who are paid under the Medicare physician fee schedule.

These reforms should include a multi-year period focused on aggressive development and application of new payment models in Medicare. Providers should be incentivized to transition toward value-based systems of health care delivery and provider reimbursement. New value-based payment systems could involve the forms of payment discussed above (patient safety initiatives, PCMHs, ACOs, episodic bundling, and global payments), as well as value-based payment updates to Medicare's fee schedule for those providers who demonstrate high performance.

Implementing these payment reform models across the public and private sectors will provide meaningful incentives to move the system in the direction of delivering higher-quality, more efficient care. As a result, health care costs will be driven down for all of us. By allowing providers and payers across the enormous diversity of health care settings to determine the appropriate application and pacing of implementation, we built in the flexibility necessary to achieve the goal of moving toward payment via value-based models over the next five years. This strategy, coupled with an effort to align public and private implementation work, will send a coherent signal to health professionals and facilities about what society values and expects, and it will create a competitive environment among providers on cost and quality.

One Approach to Replacing the SGR

The American College of Surgeons' Value-Based Update proposal (VBU), which provides for a quality-based, varied set of payment update factors for physicians based on their performance, and which includes episode-based payment updates that are tied to specific quality measures for a range of conditions, is one example of an alternative to the current Medicare sustainable growth rate (SGR) payment update formula.[49]

The SGR has historically targeted the volume of services. To be consistent with a move toward health care value, the American College of Surgeons has contemplated dissolving the SGR and moving to a new updated target system that would be tied to condition-specific, value-based targets. The update for physician payments would define the specific conditions and the targets within those conditions. Physicians would self-select their update, in accordance with their appropriate clinical practice, based on the conditions or families within which they must meet the target in order to receive next year's update. In this VBU model, target areas would be more patient-centered and include examples of targets such as improvements in chronic care, cardiac care, digestive diseases, cancer care, women's health, and children's prevention services. This value-based update replaces the SGR and is designed to incorporate all the other CMS performance measurement systems, such as PQRS and VBM, to create a top-to-bottom alignment in a value-based delivery system.

2 Pay for Care that Is Proven to Work

The Problem

Changing how we pay for health care services is only part of a multifaceted approach to bending the cost curve and improving outcomes. The quality and effectiveness of the services we pay for cannot be overlooked. Today, estimates suggest that as much as 30 percent of care in some categories is not justified by scientific evidence.[50] Sometimes, patients have diagnostic tests or treatments that may not be beneficial. At other times, patients undergo surgery or treatment regimens that are more sophisticated and expensive than other lower-cost treatments that could achieve the same result. Current payment methods provide no incentive for physicians or patients to choose the most effective, least costly alternative, or to pursue conservative treatment before undergoing high-tech, high-cost treatment that may not produce a better result.

Public and private payers should provide appropriate payment for those tests and treatments that have proven to be clinically effective and help people achieve good outcomes and less for those where evidence is insufficient. This approach will help restrain health care expenditures without limiting access to beneficial services. Under current law, and following years of precedent, Medicare generally covers any treatment that is deemed "reasonable and necessary," regardless of the evidence on the effectiveness of that treatment or the cost in relation to other treatment options. Similarly, with only the rarest exceptions, Medicare currently assesses the strength of evidence in determining coverage policies but does not use evidence when setting reimbursement rates. Instead, it links reimbursement in one way or another to the underlying costs of providing services.

Comparative research provides evidence on the effectiveness, benefits, and detrimental effects of different treatment options.[51] Without consulting this evidence, a fee-for-service (FFS) payment approach drives costs up without demonstrating that more expensive care options are better than less costly alternatives. And too often, Medicare coverage decisions affect the coverage policies of private payers. As a result, to the extent that Medicare continues to rely on its current payment systems for services, significant inefficiency will continue throughout the health care system.

Action 2: Apply a value-based pricing model for new services covered under Medicare so that higher reimbursement is awarded only upon evidence of superior effectiveness.

Congress should change the statutory language on Medicare pricing to a system in which first-time prices for new treatments are set in conjunction with a determination of their effectiveness compared to services currently covered by Medicare. This approach is based on a simple principle: that Medicare beneficiaries (and taxpayers) should not pay more for a particular service when a similar service can treat the same condition and produce the same outcome at a lower cost.

When Medicare determines that a service will be covered, it should be required to determine the service's level of effectiveness according to the following three categories (each of which is linked to an associated reimbursement strategy): 1) demonstrated *superior* comparative clinical effectiveness, 2) demonstrated *comparable* clinical effectiveness, or 3) *insufficient evidence* to determine comparative clinical effectiveness. Evidence would initially focus on high-cost technologies that are likely to be used in significant volume.

6. **Superior clinical effectiveness**: The first category of reimbursement should include a service for which there is adequate evidence to demonstrate that it is more effective, has fewer side effects, or both compared to the most relevant clinical standard. Payment for a service with this level of evidence would be set according to current Medicare policy at a rate sufficient to reimburse providers for the cost of providing what is, demonstrably, a superior service.
7. **Comparable clinical effectiveness**: For a service with evidence sufficient to determine that its clinical effectiveness is comparable to existing services covered by Medicare, payment should be set at a level equal to the existing service. Payment along these lines would be a form of "reference pricing" that is familiar within the pharmaceutical arena where payers reimburse brand-name drugs at the same price as equally effective generic alternatives.
8. **Insufficient evidence on clinical effectiveness**: The third category of comparative effectiveness evidence would include those services that meet Medicare's usual standard for "reasonable and necessary" services (e.g., those services that have been demonstrated to be safe and effective but that haven't necessarily been compared with existing treatments). Payment for these services should be set according to the current Medicare fee schedule or negotiated rates with the private sector, but only for an initial period of time. After the initial period, if additional evidence demonstrates that the new service has clinical advantages, the current payment formula would continue. If however, the evidence shows no clinical advantages or is insufficient, payment would be lowered based on current market reference price for similar covered services.[52]

Case Study

Value-Based Pricing in Practice: A Case Study of Drug-Eluting Stents

As an example of how this approach would work, consider how Medicare coverage and reimbursement decisions were made for new drug-eluting stents (DES), a therapy that is used to treat coronary artery disease, when they were introduced into practice in the early 2000s. These stents were a promising new therapy for percutaneous coronary intervention (PCI) procedures because they delivered drugs that helped prevent inflammation and narrowing of arteries. However, at the time that these stents first gained coverage within Medicare, there had been no rigorous studies comparing the effectiveness and potential detrimental effects of DES to existing covered therapies. Nonetheless, following current Medicare payment policies, the initial reimbursement for DES was set in recognition of the increased cost and the complexity of its treatment process. Initial reimbursement for one DES, the sirolimus-eluting stent, was about $3,200, compared to the $600 payment for its alternative. This scenario led to a surge in use of DES around the country. For payers, the financial impact was also rapid: It was estimated that the switch to DES for all U.S. PCI patients resulted in $600 million in increased annual health care spending.[53] Evidence now shows that less use of DES among low-risk patients has significant cost-saving potential without losing clinical benefit.[54]

In contrast, consider how coverage and reimbursement could have been managed for DES according to our proposed reimbursement approach. At the time of its introduction, a Medicare coverage determination would have been accompanied by a determination by Medicare that there was insufficient evidence with which to judge the superior clinical effectiveness of DES against alternative treatments. Following this determination, DES would have been slated for payment through the usual pricing policies for a limited period of time. However, instead of these prices continuing indefinitely without conditions, a decision window would have created an incentive for manufacturers and clinicians to perform the research needed to evaluate the clinical performance of DES versus other therapies. DES would still have been available to patients, but there would have been strong incentives for using DES appropriately and developing less expensive technology.

What the Evidence Shows

Paying for Care that Is Proven to Work

The evidence-based pricing strategies described above would build on reimbursement mechanisms such as Medicare's least costly alternative (LCA) policy as well as reference pricing strategies that are used in the private market. Reference pricing refers to a standard price that is set for a drug or health care service. If health plan members select a more expensive drug or service, they pay the allowed charges above the reference price.

Although dynamic pricing has not been applied as fully in practice as outlined above, it has the potential to reduce spending by linking evidence on the relative effectiveness of various interventions with reimbursement. Findings from relevant literature, including the following, indicate the potential that such policies have to generate savings:

Reference Pricing for Medical Procedures

- Using reference pricing for hip and knee replacements in the California Public Employees' Retirement System (CalPERS) has reduced costs per procedure by 25 percent while increasing the volume of surgeries performed by preferred providers by nearly 7 percent.[55]
- By applying reference pricing to reimbursement for colonoscopy screenings, where charges have previously been found to vary considerably (ranging from $900 to $7,200 within one region), Safeway cut its spending on colonoscopies by 35 percent while increasing the number of employees who obtain colonoscopies by 40 percent.[56]

Reference Pricing for Prescription Drugs

- Evidence from the United States and from around the world indicates the potential cost savings of reference pricing for prescription drugs. For example, the State Employee Health Plan of Arkansas applied a reference pricing strategy to proton pump inhibitors (used to treat acid reflux) by setting reimbursement at the level of the acid-reducing drug that was available over the counter. This policy yielded savings of 49.5 percent PMPM, and it reduced copayments by 6.7 percent per claim without changing utilization.[57]
- Evidence from across Canada, Europe, and New Zealand indicates that reference pricing consistently results in reduced drug spending.[58]
- An analysis performed by the Department of Health and Human Services' Office of Inspector General in the early 2000s found that applying Medicare's least costly alternative policy to clinically comparable luteinizing hormone-releasing hormone agonists, which are used to treat prostate cancer, would have saved Medicare $33.3 million per year.[59]

Paying equally for comparable results is a powerful principle, and a "value-pricing" model would allow it to be implemented without uprooting the entire incentive system for innovation. A limited initial time period for comparable payment would create a significant incentive for manufacturers to conduct comparative studies. For providers, this approach offers the prospect of better evidence with which to care for individual patients, as well as the evidence necessary to make decisions about investing in new services that may be equally effective but more costly. Using comparative evidence to set reimbursement rates at the time of coverage seems to be a promising option that should be explored to help constrain unnecessary Medicare costs.

3 Incentivize Consumer Engagement in Care

The Problem

Today, many consumers and patients lack the information or incentives they need to make informed choices when they use health care services. They often do not know what the price is likely to be before they begin a course of treatment, nor do they always know whether one particular treatment is likely to be more effective than another. Consumers are limited in their ability to make decisions that reflect their interests and preferences because they don't always have access to the information that they need to make these decisions and because there often is no financial incentive for a patient to become engaged in these decisions.

Just as we recommend changing provider payment to recognize high-value performance, we should provide health care consumers with the resources necessary to identify both high-value services and high-value providers.

The goal of benefit redesign is to create financial incentives for consumers to make more informed health care choices, leading to savings from improved adherence to preventive measures and evidence-based care; lower utilization of unnecessary services; and use of more efficient, higher-quality providers.

Health plans and employers have begun to redesign benefits to encourage the utilization of higher-value providers, treatments, and services. One emerging strategy, Value-Based Insurance Design (VBID), relies on clinical research and data on provider performance as the basis for offering incentives to consumers (such as reduced cost-sharing) to use evidence-based treatments and services and to obtain care from providers with a demonstrated ability to deliver quality, efficient health care. By using solid, peer-reviewed evidence of the clinical effectiveness of services and widely recognized measures of provider performance (such as those endorsed by the National Quality Forum, or NQF), VBID modifies insurance design in ways that encourage consumers to select high-value services and providers.

States are also leveraging VBID to improve the value of care for their Medicaid populations. For example, Minnesota's Medicaid Incentives for Diabetes Prevention Program offers Medicaid patients who've been diagnosed with pre-diabetes or with a history of gestational diabetes the opportunity to participate in an evidence-based Diabetes Prevention Program. Participants can earn incentives, such as cash uploaded to a debit card or membership at the YMCA, for attending classes and meeting weight loss goals.[60] The Connecticut Medicaid program runs Incentives to Quit Smoking, a program that provides cash incentives to encourage enrollees to use tobacco cessation services and to quit smoking.[61] Similarly, in Florida's Enhanced Benefits Accounts program, the state developed a list of 19 healthy behaviors (including wellness behaviors, participation in programs that change lifestyle behaviors, and appropriate use of the health care system) that allows participants who adopt these behaviors to earn rewards.

Medicare's Physician Value-Based Modifier (VBM) program is scheduled to be phased in beginning in 2015. It will include both quality and efficiency data to calculate payments to physicians. Implementation of the VBM, along with Medicare's Hospital Value-Based Purchasing (HVBP) program, are important initial steps toward aligning provider incentives with the provision of quality, efficient care within Medicare's fee-for-service (FFS) program. Yet, the current structure of Medicare's benefit design does not provide individuals or families with any corresponding incentive to make value-based decisions about their use of health care. Deductibles and cost-sharing are uniform across providers and fail to differentiate in terms of value for treatments, services, and providers. Given the wide variation in cost and quality across providers, drugs, and services, shifting demand to those that demonstrate good value would be a much better allocation of resources.

Continued adoption of Medicare's hospital and physician value-based programs will optimize these efforts by using the results of the quality and efficiency determinations to encourage beneficiaries to act on this information. To realize the full potential of these value-based programs, we recommend specific changes to the Medicare program, as well as the promotion of increased utilization of VBID in the private sector.

These suggested actions are guided by the following principles:

- VBID should apply to all payers (public and private), and incentives for consumers and providers should be aligned.
- VBID should be evidence-based.
- VBID should support both a reduction in the use of low-value services and an increase in the use of high-value services.
- VBID efforts should take into consideration the needs of vulnerable populations by including targeted support for those populations, as well as for individuals with multiple co-morbid conditions.

Action 3a: Modify traditional Medicare benefits to allow tiered cost-sharing for providers, drugs, and services, provided that the modifications do not alter the overall actuarial value of Medicare for beneficiaries.

In the short term, this could be done via authority given to the Centers for Medicare and Medicaid Services (CMS) to launch pilots that assess the impacts on cost, quality, and patient experience. As the physician and hospital value modifier programs mature, the results can be used as the basis for expanding the pilots across the Medicare program to more broadly implement differential cost-sharing based on value.

Action 3b: Allow Medicare Advantage plans to use tools that promote quality and value, such as using VBID incentives to induce beneficiaries to choose high-performing networks, or varying their cost-sharing based on the clinical effectiveness and value of services. Additional cost-sharing flexibility should also be applied to the Medicare Shared Savings Program and the Pioneer ACO Initiative to enable them to tier cost-sharing based on quality performance and the clinical effectiveness of services.

Currently, Medicare Advantage plans are not permitted to vary copayments within their provider networks, making them unable to differentiate higher-value providers from lower-value providers. In addition, such plans are not permitted to charge beneficiaries more than Medicare FFS for services of low value, again limiting their ability to align cost-sharing with value.

The provider performance data that are used to calculate hospital and physician payment modifiers, as well as data on the comparative effectiveness of treatments and services, should be used to promote value-based choices by beneficiaries in Medicare Advantage plans by allowing such plans to tier providers and services based on value and to offer beneficiaries cost-sharing incentives to act on this information.

Action 3c: Augment opportunities for value-based benefit design in Medicaid and the private sector.

While the private sector and Medicaid are already making progress in implementing value-based insurance design, there are additional opportunities for them to encourage the use of high-value services and providers. For example, the new state health insurance marketplaces (also known as exchanges) should strongly encourage all participating health plans to offer a value-based insurance design option by 2019. These plans should vary cost-sharing for services based on value and for providers based on performance and quality data.

By aligning provider incentives to deliver high-quality, more efficient, more effective care with consumer incentives to select high-quality, more efficient, more effective care, the health care system will begin to move down the path toward sustainability. Today, health care consumers and patients face substantial and growing out-of-pocket costs, but they lack the information and financial incentives necessary to make more informed health care choices. As a result, they are unable to "vote with their feet" and choose higher-performing providers, tests, and services. Changing provider payment or coverage policies alone, as described in Actions I and II, will not stimulate the change in incentives that we believe is essential to creating real health system reform. The same evidence about clinical effectiveness, quality, and cost that underlies provider and service payment reforms must also be used to help health care consumers make smart choices. Aligning provider payment, the reimbursement of services, and consumer incentives will drive all players within the health care system to make real change.

What the Evidence Shows

Value-Based Tiered Cost-Sharing

Value-based tiering, a form of VBID, modifies cost-sharing to reflect the relative value of services. It reduces cost-sharing for services where there is a body of evidence indicating that they are high value in terms of both clinical effectiveness and cost effectiveness, and it increases cost-sharing for those services that are not indicated to be clinically effective or cost effective based on evidence. A growing body of literature shows the potential of such policies to increase adherence to treatment protocols and to reduce costs. Examples include the following:

- In the private sector, use of VBID has resulted in savings stemming from a shift to healthier behaviors and higher-value care choices. For example, Aetna's Active Health Management program has focused its VBID efforts on high-value medications that are used to treat common chronic diseases, such as hypertension, diabetes, high cholesterol, and asthma. By lowering copayments for ACE inhibitors and angiotensin receptor blockers (ARBs, used to treat hypertension), beta blockers (used to treat hypertension), medications for glucose control (used to treat diabetes), statins (used to treat high cholesterol), and inhaled steroids (used to treat asthma), the plan was able to increase adherence to medications by 3 percentage points.[62]
- When employer Pitney Bowes reduced copayments for two essential heart drugs, patients filled more prescriptions, ER use and hospitalizations were reduced, and overall health spending declined. Pitney Bowes also reduced copayments for diabetes and asthma drugs. As a result, the median cost for employees with these conditions fell by 12 and 15 percent, respectively, over a three-year period.[63]
- Evidence from Novartis's experience with reducing cost-sharing for cardiovascular medicine shows that adherence to such medication regimens went up by 9.4 percent without increasing health care costs.[64]
- One study simulated the potential cost savings that could be generated by reducing copayments for cholesterol-lowering drugs for Medicare beneficiaries with diabetes. It found that if copayments were reduced to $25, Medicare would save $262 in Part A and B costs per beneficiary, with even greater savings ($558) for high-risk beneficiaries.[65]

Value-Based Provider Networks

Value-based provider networks tier health care providers and facilities based on performance metrics, including cost efficiency and measures of quality. Copayments are reduced for those providers and facilities that fall into a higher-performing tier and are increased for those providers and facilities that fall into a lower-performing tier. A growing body of data indicates that such networks can help drive consumers to better-performing providers and facilities while helping reduce spending. Examples include the following:

- UnitedHealthcare's UnitedHealth Premium program divides providers across 21 specialties into tiers based on quality of care and cost efficiency, with the best-performing providers receiving "Premium Two-Star" designation. The program yields estimated average savings of 14 percent, with savings ranging from 7 to 19 percent depending on physician specialty.[66]
- Aetna's Aexcel tiered provider network uses clinical performance and cost efficiency criteria to divide providers in 12 specialties into tiers, and it allows employers to set the level of incentives to drive employee behavior. Aetna reports that Aexcel providers are demonstrated to be 1 to 8 percent more cost efficient relative to non-Aexcel peers within a given network.[67]
- BlueCross BlueShield of North Carolina data on their tiered benefit plan indicates that savings of up to 10 percent can be generated by dividing in-network hospitals and selected specialties (general surgery, OB/GYN, cardiology, orthopedics, and gastroenterology) into two tiers based on quality, cost efficiency, and accessibility.[68]
- A study of PacifiCare Health System's (now UnitedHealthcare) network in California found that its use of tiers has resulted in 20 percent lower health care costs and 20 percent higher quality.[69]
- Other payers and purchasers, such as CalPERS, have lowered patients' costs if they seek care from Centers of Excellence or from providers who are likely to achieve good outcomes based on historical performance. One national plan that uses provider performance as the basis for developing a tiered provider network and that offers reduced cost-sharing to consumers who seek care from high-value providers has seen a 14 percent reduction in costs per episode for care delivered by physicians who've been designated as providing higher quality and efficiency versus non-designated physicians.[70]
- In addition, Lowe's, a national chain of home improvement stores, recently instituted a pilot program for major cardiac procedures that will contract with centers of excellence. Plan enrollees that use the Cleveland Clinic face no cost-sharing for their cardiac procedures and are reimbursed for related travel expenses. While savings data have not yet been made publicly available, Lowe's is expanding its contract with the Cleveland Clinic to include spinal procedures and care for back pain.[71]

4 Improve the Infrastructure Needed for an Effective Health Care Market

The Problem

Each of the actions described in this document involves reallocating health care resources to ensure that quality and health outcomes will be improved while the growth in health care expenditures is contained. We want to move to a system where health professionals, managers, patients and families, and public officials consult the evidence of "what works" when making program and personal decisions. Today, however, we do not have an easily accessible body of knowledge that each of these stakeholders can consult when making these decisions, and we do not have a trusted way of explaining our decisions to each other or of updating the body of knowledge on which decisions are based. In this section, we focus on the need for better data and a sufficient workforce to support a coordinated care environment. We also recommend strategies to simplify administrative processes, to reform medical malpractice policies and practices, and to ensure that markets stay competitive.

Develop a Shared Knowledge Base for Patient and Provider Decisions

Action 4a: Expand the authority to consider research on treatment effectiveness.

Consumers and providers have a right to know which treatments and technologies work and which are less effective. To expand this evidence base, Congress should provide new authorizing language for the Patient-Centered Outcomes Research Institute (PCORI), or some parallel agency, that explicitly allows it to consider research on cost effectiveness as a valid component of patient-centered outcomes research. PCORI and the Agency for Healthcare Research and Quality (AHRQ), in their funding of research on the effectiveness of treatments and technologies and their dissemination of the results of that research, should prioritize the establishment of multi-stakeholder, deliberative processes that can use such research to provide trustworthy recommendations on high-value and low-value care options to providers, payers, and patients.

Generate Information to Support Improved Care

The infrastructure for measuring how well our health system performs is incomplete, disconnected, unnecessarily expensive, and inefficient. There is wide variation in the effectiveness of treatments, their appropriate use, and how well providers follow recommended practice guidelines or achieve desired results, but there is no single source of well-organized data that would allow for the consistent evaluation of provider performance. Many measures of provider performance exist, but they are not prioritized or consistently used across federal and private programs and systems. This limits the ability to compare performance based on value, and it increases the reporting burden.

The electronic infrastructure to support reporting is also inadequate. A recent RAND report paints a stark picture: Modern health IT (HIT) systems have not been widely adopted, and those that are in use often are not interoperable and are not used effectively.[72] HIT systems must be interoperable if they are to improve patient care, reduce duplication of services, and assist clinicians in their decision making at the point of care. Interoperability will also allow registries and other longitudinal health records to function together so that measures of health outcomes over time (and for sub-populations) will become possible.

One of the barriers to wider adoption of HIT is the reality that, for the most part, the infrastructure and the tools that are necessary to achieve the desired level of interoperability and information sharing are not yet available in the market. Vendors should meet HIPAA and other standards to make the infrastructure and tools useful to providers and other users of the system.

Meaningful use requirements play an important role in efforts to build a national HIT system where clinicians can securely exchange information with other providers. However, these requirements currently apply only to a select group of eligible hospitals and professionals and not to the larger data ecosystem, such as mental health providers, labs, pharmacies, public health clinics, long-term care facilities, and other providers. Furthermore, current incentives for adopting meaningful use standards may be inadequate to drive adoption within the timeline needed.

Action 4b: Prioritize the development and adoption of uniform measures and advance electronic data collection to support reporting.

A critical piece of the foundation is a simplified measurement framework where all payers use a consistent set of measures to collect the information that is required to support value-based payment and decision making. To simplify data collection and prioritize measures of health system performance, we recommend that the federal government and private-sector stakeholders identify a parsimonious set of meaningful and useful performance measures, focused on high-priority health conditions where performance varies widely, building on the work begun by the National Quality Forum and expanding the scope to include all major public programs and commercial populations. By 2016, this information should be translated into a uniform national core measurement set that is used by both the public and private sectors and that is consistent with the National Quality Strategy. In building this measurement set, current measures that are not considered helpful for clinical quality improvement or accountability programs (e.g., public reporting and provider payment incentives) should not be included. At the same time, the measurement set should address the gaps that currently exist, e.g., clinical outcomes, patient-reported outcomes, care coordination, patient experience, total cost of care, and appropriateness. Such a measurement set can help promote consistency for providers and patients and ensure comparability across the sectors, regionally, and nationally. To support local community needs, the core measurement set could be augmented with measures that best address the characteristics of the local population. To efficiently report on these core measures, a robust health information technology infrastructure is needed with health IT vendors building the capabilities to allow reporting through electronic health records (EHR) systems.

Second, CMS should make differential payments for provider adoption of and reporting of the core set of metrics on the priority conditions. These incentive payments should also be made available to health care providers besides hospitals and physicians, and these payments should be supported by Medicaid and private payers through their provider contracting. Ultimately, we need to move more quickly toward a national health IT system in which approved users can get the data they need and create competition within the vendor market to develop the needed data-sharing capabilities.[73]

Leveraging the Meaningful Use program and a health IT roadmap developed by the National Coordinator for Health IT and CMS could provide guidance on technical requirements for extraction, analysis, and reporting of data on the priority conditions referenced above. This includes criteria for EHR technologies, data intermediaries and aggregators, clinical decision support, benchmarking and feedback systems, and public reporting. Such a roadmap should not prescribe specific decision support rules, functions, or user interfaces, but it should establish requirements and a timeline by which those capabilities are in place for all providers that do business with public health insurance programs such as Medicare and Medicaid.

What the Evidence Shows

Health Information Technology (HIT)

A number of studies have found that HIT reduces unnecessary utilization of services and leads to cost savings, but overall, the evidence is mixed.[74] Thus, HIT is not a magic bullet. It will take years to achieve the full potential of EHRs and decision-support tools, but over time, HIT is an investment in a "public good" that will improve care delivery and patient outcomes, reduce administrative waste, and lower total spending.

Align Workforce Policies to Support Multi-Disciplinary Care Teams

To maximize the impact of the payment reforms and quality improvement strategies described elsewhere in this document, we need a paradigm shift in how care is delivered—in private practices, hospital units, and nursing facilities across the country. The old paradigm in which a single provider heroically brings each patient back to health is increasingly inadequate for today's challenges. The future of our health care lies instead with multi-disciplinary care teams. These teams mobilize a range of providers (specialists, nurses, primary care clinicians, home health aides, and community health workers), all practicing at the top of their license and ability. They have the capacity to manage the health of a broad patient population and collaborate on quality improvement initiatives.

Where these team-based practice and delivery approaches have been tested, they have demonstrated the capacity to improve outcomes and patient satisfaction while lowering costs. In order to apply this approach more broadly, however, our health care workforce—and workforce policies—must be redesigned.

Action 4c: Implement a multi-pronged workforce strategy.

We recommend four strategies to enhance our health care workforce, as follows:

1. Existing scholarship and medical loan forgiveness programs should be modified to address our most acute workforce needs, including provider shortages in primary care specialties and in medically underserved geographic areas. Federal nurse education funding should be refocused to equip registered nurses to assume the roles of case manager and population health coordinator.
2. Because face-to-face contact with all members of a care team is not always possible, training and resources to support telemedicine, bio-monitoring, and virtual access to providers should be expanded. The new payment models need to support these types of interactions among caregivers and patients wherever follow-up and minor health care assessments can be more conveniently conducted through these methods.
3. To help fill gaps in our health care workforce, more should also be done to facilitate the credentialing of veterans for health care jobs. Federal resources should be committed to expanding efforts to translate military health care training and experience into credit toward professional licensure in occupations in the health care field.
4. Today, as care teams become more important to the delivery of health care, states are considering adjusting their licensing regulations. Federal policymakers should remove federal-level regulatory barriers that prevent states from making optimal use of non-physician providers in care teams.[75]

Reduce Administrative Overhead

Administrative processes are burdensome and are key contributors to the waste of health care resources in this country, making up a full 14 percent of total U.S. health spending.[76] Methods for routine administrative transactions among providers and health plans are often overly complex and duplicative. For example, credentialing and periodic re-credentialing of providers by health plans requires physicians and other providers to provide information on their medical education and training, medical licenses,

malpractice history, and work history.[77] Although a standardized form for doing such credentialing is available, some providers continue to use different credentialing forms for each health plan that their practice accepts.

Communication among health plans and providers regarding key transactions is another area that is ripe for administrative simplification and savings. The Affordable Care Act established new requirements aimed at reducing administrative costs for health plans and providers by increasing the use of enhanced electronic transactions. For example, HHS must adopt new standards and operating rules for how plans communicate information electronically for key transactions that take place among health plans and providers, such as eligibility determinations, claims status updates, claims payments, and electronic funds transfers to physicians and hospitals. CBO estimates that these provisions will achieve a total federal savings of $11.6 billion.[78]

Providers have made significant progress in moving toward filing claims for payment electronically. According to a recent survey, the percent of claims submitted and processed electronically has more than doubled, rising from 44 percent in 2002 to 94 percent in 2011.[79] However, for the full promise of administrative simplification to be fulfilled, health plans, providers, and the vendors they use must work toward achieving greater administrative simplification through streamlined electronic transactions that take steps beyond just electronic claims filing. For this to occur, health plans, providers, and vendors should adopt and use the same health information technology standards to conduct electronic transactions related to eligibility determinations, claims status updates, claims payments, and electronic fund transfers.

Action 4d-i: Streamline the credentialing process by promoting the use of a single system for provider credentialing across both public and private payers.

A 2004 study conducted by the Medical Group Management Association (MGMA) committee found that physician practices submit an average of 17.86 credentialing applications per physician per year.[80] The Council for Affordable Quality Healthcare (CAQH) has created a single credentialing application and a Universal Provider Database (UPD) in which applications are stored electronically and can be accessed by health plans and public payers. The UPD is currently used by more than 1 million providers.[81] However, Medicare does not use the UPD—instead it requires physicians to be credentialed through its Provider Enrollment, Chain, and Ownership System (PECOS) system. Given that duplication of credentialing processes adds cost and confusion to the health care system, we recommend that all payers, both public and private, use a single system for provider credentialing.

What the Evidence Shows

Standardized Credentialing

The Medical Group Management Association estimates that the $2.15 billion a year that the U.S. health care system spends on credentialing could be slashed by 90 percent if all payers used a single system. CAQH estimates that the UPD saves providers nearly $135 million per year in administrative costs.[82]

Action 4d-ii: Build on the Affordable Care Act by requiring that providers and vendors transmit and receive documents electronically following the same electronic standards and operating rules that health plans are required to implement under the health care law.

With the evolution of the payment and delivery system reform landscape, we expect that there will be further changes to underlying businesses process and associated transactions among payers, providers, and vendors. Already, under Medicare, providers are required to file claims electronically, receive electronic funds transfers, and receive remittance advice electronically. Conducting these functions and those specified by the Affordable Care Act with health plans in the commercial market will result in streamlined electronic data interchange among health care stakeholders. It will also have the benefit of stimulating vendors of practice management systems to design systems that facilitate these electronic transactions.

What the Evidence Shows

Electronic Billing

In a 2010 report, the Institute of Medicine calculated total administrative costs of $361 billion (in 2009 dollars) and estimated that approximately 42 percent of this total ($149-$160 billion) could be saved annually if administrative complexity could be reduced.[83]

Reform Medical Malpractice Laws and Procedures to Reduce Waste and Improve Care

The U.S. medical liability system is largely dysfunctional. It diverts scarce resources from health care while failing to promote better care or to reliably provide compensation to patients who've been harmed. The vast majority of injured patients never receive compensation. Yet fear of litigation encourages overuse of care and procedures and chills provider-patient communication. Instead of advancing pragmatic solutions to these problems, policymakers at the national level are locked in a stalemate over controversial proposals to cap damage awards and attorney fees.

Action 4e: Adopt innovative approaches to resolving medical disputes that promote patient-provider communication, improve quality and safety, and promote fairness.

Reducing medical malpractice itself, through systematically improving patient safety, patient satisfaction, and quality of care, is the most important way to reduce potentially litigious adverse events, harm to patients, and related costs. There is also growing evidence that better management of adverse events by improving communication among patients and their families is an important factor in reducing malpractice program costs. We also support the following initiatives:

- **Certificate of merit**. To avoid spending scarce justice system resources on less meritorious cases, we support evaluation of the merits of claims by independent medical experts prior to filing. Such a process should be required to consider whether the care provided was consistent with evidence-based care guidelines and best practices. Routinely evaluating quality of care data has been found in several states to help inform both plaintiff and defendant decisions regarding whether to proceed or to settle such disputes prior to court action. Although

the results of the review should not be used as evidence at trial, they can help inform decisions regarding whether to proceed or to settle the dispute by both the plaintiff and the defendant.

- **Safe harbors for evidence-based care**. We support the establishment and evaluation of safe harbors and medical malpractice protections for clinicians who effectively document and practice recognized and appropriate standards of care. A significant portion of the HHS Secretary's discretionary funding for medical malpractice pilots should be directed toward this goal.
- **Neutral medical expertise at trial.** Today, medical liability suits rely on medical "experts" who are paid for their services by either the plaintiff's or the defendant's lawyers. To ensure that courts and juries can benefit from more objective and neutral medical analysis, courts should be empowered to retain their own medical experts.

The HHS Medical Liability Reform and Patient Safety Initiative has promoted innovative pilots that focus on fostering better communication among patients and their care teams. Ascension Health has focused on improving perinatal safety since 2003, and with federal support from this HHS initiative, has trained more than 1,000 physicians and nurses on disclosure communication. The Joint Commission defines disclosure communication as when the responsible practitioner clearly explains the outcome of any treatment or procedure to the patient and family whenever outcomes differ significantly from those that were anticipated. Ascension Health has seen a 34 percent reduction in the cost of self-insured risk management programs since 2006 attributable to improvements in the case management of malpractice programs, implementation of system-wide quality and patient safety initiatives, and increased use of disclosure communication with patients when an unexpected event occurs.[84]

Ensuring Competitive Markets

One of the core principles of our comprehensive proposal is that healthy competition in health care markets based on cost, patient experience, and health outcomes is the best way to drive innovation and improvement. Healthy, competitive markets rely on a solid foundation of information that is available to consumers, payers, and providers. This information is also needed to support the provider and consumer incentives that are the engines for greater efficiency and quality improvement.

Based on this principle, we propose three goals and five actions. The goals are as follows:

1. Promote competition, efficiency, and innovation in health care markets through appropriate oversight and review by the appropriate federal and state agencies.
2. Support the use of appropriate consumer incentives to enable the development of innovative, value-based insurance designs that reward consumers who choose high-quality, efficient providers and services.
3. Enhance the availability of performance information on quality and affordability to enable the development of a complete picture of a providers' performance across all patients and payers, which is needed to support the first two goals.

Action 4f-i: Continue hearings on competition.

Two ideas, which at times conflict, have gained acceptance with respect to health care markets: (1) market consolidation has led, in some markets, to anti-competitive developments that could result in the lack of consumer choice and may raise prices for consumers; and (2) the transition to a system of care that is more efficient and higher-quality requires increased levels of coordination among providers, payers, and, in many cases, employers. Further complicating the issue is the possibility that some government regulations may impede more efficient forms of provider accountability and coordination. At the federal level, the Federal Trade

Commission (FTC) is well-positioned to continue its examination of these issues and provide insights that can advance both increased competition and improved coordination in such markets.[85] The FTC has often convened public hearings on competition issues and market-based efforts to increase efficiency. Future hearings should include a focus on a range of markets and conduct with different characteristics. The hearings should explicitly address: (1) what can be learned from the history of market consolidation and the range of impacts on prices, access to care, quality, and innovation; (2) whether unnecessary or counterproductive impediments to efficient arrangements may be inadvertently created by the fraud and abuse laws and, if so, whether and how best to address them; and (3) what the state of competition is in health care markets and what are the key policy and other recommendations with respect to competition in such markets.

Action 4f-ii: Increase the transparency of market analysis and insights by the FTC and DOJ.

Given the rapid pace of consolidation and reconfiguration in many health care markets, the Federal Trade Commission (FTC) and the Department of Justice (DOJ) should create further transparency, within statutory and other limits, in their analysis of and insights into market competition issues in health care. This can occur through many avenues, including speeches, testimony, closing statements, and reports. In addition to these approaches, the FTC and the DOJ should share information with relevant state agencies regarding reviews of potentially anti-competitive behavior in a state's health care market building on significant guidance already in the public domain.[86]

Action 4f-iii: Ensure adequate funding for competition agencies.

Adequate funding should be provided for state and federal antitrust agencies to investigate, and, where appropriate, challenge anticompetitive behavior in health care markets. States are encouraged to monitor anticompetitive behavior and take appropriate regulatory or legislative action.

Action 4f-iv: Support the use of appropriate consumer incentives.

As discussed earlier, innovative, value-based benefit designs have been recognized widely as an important element of the transformation of the health care system from one characterized by silos of information and limited consumer engagement to one in which information is both shared and used to enable consumers to pursue more efficient and higher-quality care. Certain practices, however, have created impediments to the movement to such value-based designs. All-or-nothing contracting and refusals to participate in tiered networks (or refusals to be placed in less than the highest tier) have created substantial roadblocks in certain markets. These roadblocks are likely to impede the development of innovative, value-based products in the new health care market. As a general rule, and in most circumstances, these practices should be avoided.

Action 4f-v: Enhance the availability of performance information on quality and affordability.

Health plans that participate in Medicare Advantage are required to report on and make available information about quality as one way of helping beneficiaries make decisions about their health plan choices. In addition, commercial and Medicaid plans report quality performance and patient experience data to organizations such as NCQA and URAC(together with other data that are required for plans undergoing accreditation). Quality performance and accreditation data, such as HEDIS are used by NCQA to create a national ranking of health plans, and these reports are made publicly available. Oftentimes, private employers also require specific quality measures that are important to their employees to be reported and made available to employees. For health plans that will be offering coverage through a health insurance marketplaces (or exchange), accreditation and the quality data reporting that is associated with the accreditation process will be a requirement for offering a qualified health plan. As a result,

consumers have access to different types of quality and satisfaction information depending on how they get their health coverage.

Efforts have also been made to make hospital quality data available through Medicare's Hospital Compare website, which has information about the quality of care at more than 4,000 Medicare-certified hospitals. Similar efforts are underway to provide quality data on Medicare-enrolled physicians and other health care professionals.

Despite this progress, it is still often difficult to assess the quality, efficiency, and appropriateness of care because there is no source of aggregated information that represents all the patients of a particular provider. As a result, consumers and employer purchasers are often limited in their ability to identify and choose providers who offer the potential of high-quality, affordable services. In addition, health plans face limits in their ability to identify high-performing providers for the purposes of value-based benefit design to support consumer choice. Consumers and other purchasers of care should have ready access to reliable, consistent, and relevant measures of health care cost, quality, and customer satisfaction levels, as well as comparable information on health plans. The purpose of doing so would be to make available to stakeholders meaningful comparative information on consumer cost-sharing, utilization, and performance with respect to certain quality metrics while ensuring the privacy of patients. For example, the data aggregation could be used to do the following:

- Publicly report data on the quality of private health plans
- Publish doctor and hospital ratings to enable informed consumer choice
- Provide health plans with data for product and network development
- Supply doctors and medical groups with analytics and benchmarking for quality improvement
- Be a resource to advance innovative payment and performance models

Ideally, there would be mechanisms for developing such information on provider quality and prices (recognizing that the price information that is provided needs to evolve with and reflect new models of payment and delivery), as well as consumer cost-sharing. Access to these data would be provided, consistent with existing FTC/DOJ guidance on how to make data public while protecting competition. Provider performance information based on aggregating multi-payer administrative data, together with clinical data from registries or EHRs, can result in more meaningful and reliable results than analyses based solely on one payer's data (e.g., Medicare).

States should take advantage of the "qualified entities" under the Availability of Medicare Data for Performance Measurement program to link Medicare, Medicaid, and commercial claims data. The variations in and evolution of payment models, state markets, and information systems, however, create technical challenges in the creation of such aggregated databases. We recommend developing mechanisms for providing this information in a way that avoids adding unnecessary costs to the health care system, protects patient privacy, enables consistent analytic results, and allows for the data aggregation to evolve with changes in payment models and methodologies.

5 Incentivize States to Partner with Public and Private Stakeholders to Transform the Health Care System

The Problem

Historically, cost containment proposals in the United States have focused on lowering prices and decreasing utilization for a single payer or expenditure category, and they haven't had a lasting impact.[87] To compound the problem, there are fundamental uncertainties surrounding current health care spending trends. In particular, will the recent slowdown in national health care spending be sustained? Will the payment and delivery reforms underway in the private and public sectors, and the further accelerations recommended in this proposal, continue to slow growth in per-capita spending?

States play a substantial and unique role in shaping the health care delivery system within their borders. Through licensure of facilities, physicians, and other personnel, and through coordinated planning of new services and construction of facilities, states can exert significant control over the "supply side" of the health system. Moreover, states can have a significant impact in related areas that represent important opportunities to both improve health and reduce future growth in costs, including promoting public health and prevention initiatives, addressing geographic variation, and improving health care quality and safety. States' jurisdiction over insurance regulations, as well as over the Affordable Care Act's new health insurance marketplaces (which will be run by the states themselves, by states in partnership with the federal government, or solely by the federal government), give states a set of levers and opportunities to work with insurers and providers to move toward payment and delivery structures that promote evidence-based quality reforms, high-value services, and better health outcomes. For all of these reasons, states are well-positioned to take a leadership role in coordinating private and public strategies to achieve innovative health system delivery and payment reforms.

In recent years, many proposals have included national targets, caps, or spending limits on federal programs. But a national target or cap fails to create an incentive for states to think creatively to implement solutions that fit their unique coverage landscapes and provider markets or to leverage their distinct capabilities. We instead support an approach that creates a shared incentive to bend the cost curve across both the public and private sectors, rather than one that would shift costs among sectors or to consumers.

An alternative approach could focus at the state level and include mechanisms to control costs across all sectors so that costs that are compressed in one sector will not simply be shifted to another. While states have a number of levers at their disposal to address total cost containment, we suggest an approach that brings stakeholders and state governments together to achieve meaningful, system-wide reforms.

The action we discuss below serves as a lever to accomplishing the other actions proposed in this brief–it is designed to ensure that payment reforms and new benefit designs have the intended effect of lowering overall costs by giving states incentives and the necessary flexibility to promote system transformation within their borders.

Action 5: Establish a gain-sharing program for states to innovate to control health care costs.

If a state elects to participate, specific savings goals would be set, along with defined rewards for states that met them. This approach differs from an attempt to reduce direct state or federal expenditures on health programs, because it focuses on overall health care spending, not just public expenditures.

It is designed to give states the flexibility to make meaningful, system-wide reforms that address local circumstances and that lower costs by refining the incentives of the payment and delivery system, rather than by cutting coverage and services.

States that voluntarily opt into such a program and that successfully slow the growth of total health spending would be rewarded with a percentage of the amount of the savings that the federal government realizes, with recognition that states with below-average costs would have lower savings targets. Shared savings payments would be generated through lower spending on Medicare, Medicaid, Affordable Care Act subsidies (for example, for residents who obtain coverage in the new health insurance marketplaces), and through savings in tax expenditures related to the exclusion from taxable income of employer contributions to health insurance premiums.

States could choose different combinations of market-based reforms and regulations, including the development of rules and contracts for payers and providers in their new health insurance marketplaces, to advance the goals being pursued by stakeholders in the state. There are several ways that payment and delivery reforms can be accelerated that would fit the specific cultures and political environments within a state. While the specific methods would be left up to the states and their stakeholders, some examples of potential strategies include the following:

- Improved care coordination and care management for those with chronic conditions.
- Health system and delivery reforms that reward high-quality care, improve health outcomes, and reduce health care costs, such as patient-centered medical homes, disease management programs, and incentive programs for wellness and prevention.
- Alignment of public and private payment reforms that reward high-quality care over volume of care, including bundled payments for episodes of care; financial incentives for providers based on consensus-based clinical measures of quality; non-payment for adverse or "never" events; and creating financial incentives to reduce medical errors, preventable hospitalizations, and hospital re-admissions.
- Scope of practice reforms to expand access to primary care by modifying scope of practice restrictions.
- Efforts to improve quality and patient safety through promotion of health information technology and administrative simplification to improve efficiency in care.

To ensure that the cost-reducing objectives are pursued in a responsible way, there are a number of benchmarks that should be set in order for participating states to receive payment:

- A state should continue to make progress in reducing its uninsured rate, especially among its low-income, uninsured residents, and any shared savings payments should not be the result of restricting eligibility or access (as this will simply shift costs and works at cross purposes with the goal of expanding high-quality coverage).
- A state should engage in a public, multi-stakeholder process to develop, implement, and monitor its plans.
- A state should not be credited for policies that result in shifting costs to consumers, among state and federal governments, between one public program and another, and between the public and private sectors. With comprehensive tracking data, this proposal's financial incentives will help ensure that effective cost containment is achieved across the entire health care system. HHS may also issue annual guidance to states on ways to avoid cost-shifting as a way to assure that policies effectively reduce costs overall.

States that opt to participate in the gain-sharing model would be required to define policies and mechanisms for sharing rewards with stakeholders who participated in developing and implementing cost containment strategies that resulted in measurable cost savings.

The source of funding for the program should not be discretionary and year to year. Instead, it should be a direct funding program to states.

What the Evidence Shows

Gain-Sharing

A state cost-containment proposal based on the shared savings approach that meets specified targets for spending reductions could result in significant savings. While there has not been a cost containment initiative to date that provides a shared savings incentive to the states in an effort to drive system-wide reform, a preliminary and conservative estimate based on an analysis of 14 years of state cost trend information illustrates the potential magnitude of savings that are possible.[88] In fact, the modeling shows that, if incentives in this type of program led half the states, on average, to successfully reduce costs by even just 0.5 percent below trend, compounded annually, roughly $220 billion in aggregate savings could be generated over 10 years (2012-2021) to be shared among states and the federal government. Increasing a state's share of total savings would increase its motivation to implement cost-reducing measures, thereby increasing the probability of higher total savings.

Conclusion

The drafters of this report represent a diverse cross-section of health care interests: patients, providers, employers, and payers. We recognize that, on specific short-terms policies, our constituents may have different positions. But because our long-term vision is unified and our commitment is strong, we believe that a series of pragmatic, incremental, and balanced policy actions can move the nation to a far more sustainable, high-quality health care system.

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POLICY NOTE

UC BERKELEY LABOR CENTER

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Promoting Enrollment of Low Income Health Program Participants in *Covered California*

Elizabeth C. Lytle, Dylan H. Roby, Laurel Lucia, Ken Jacobs, Livier Cabezas and Nadereh Pourat

SUMMARY: In 2014, over 500,000 California residents will transition from the Low Income Health Program to health coverage provided by Medi-Cal or subsidized health plans offered in *Covered California*. This policy note focuses on the transition plans for the 27,000 higher income enrollees that will be eligible for sizeable federal subsidies in the state-based health insurance exchange, *Covered California.* A successful transition with high rates of participation relies on collaboration between the Department of Health Care Services, the local Low Income Health Programs (LIHPs) and *Covered California*. Enrollees will be moving into a complex system of premium payment, plan choice, subsidies and cost-sharing reductions and their engagement in the transition is necessary to result in enrollment in health plans by January 1, 2014. Recommendations to promote success include: applying administrative LIHP and DHCS data to ease the enrollment process in *Covered California*, collaborating in communication with LIHPs and other county programs, and targeted outreach with personal assistance for potential enrollees.

Background: Low Income Health Program

Due to the Affordable Care Act (ACA), an estimated 2.4 million Californians with incomes up to 200 percent of Federal Poverty Level (FPL) will be newly eligible for no-cost or subsidized health coverage in 2014 through the Medi-Cal expansion and subsidized health plan offerings in California's Health Insurance Exchange, *Covered California*.[1] In 2010, the Centers for Medicare and Medicaid Services approved California's "Bridge to Reform" §1115 Medicaid Demonstration Waiver, which created the Low Income Health Program (LIHP). Counties receive partial federal reimbursement for providing health services through the LIHP to residents who will be newly eligible for coverage in 2014. Over 500,000 of the newly eligible individuals have enrolled in the LIHP since its inception in July of 2011 and will transition to Medi-Cal, California's Medicaid program, and *Covered California* by January 1, 2014.[2]

LIHP enrollees are split into two income-based categories: Medicaid Coverage Expansion (MCE) enrollees with family incomes up to 133% of the FPL and Health Care Coverage Initiative (HCCI) enrollees with incomes above 133% and up to 200% FPL. Nineteen LIHPs operate to service LIHP-MCE enrollees in a total of 53 counties, yet few counties chose to offer services to HCCI enrollees.[3] In December 2012, 26,375 of the 499,678 current enrollees, or five percent, were enrolled in the LIHP-HCCI program.[4] LIHP-HCCI enrollment at the time of transition is estimated to be 30,000. Assuming some limited enrollment growth and the current income distribution remaining

unchanged, approximately 27,000 will be eligible for coverage options through *Covered California* by December 2013.[5]

Additional background information on LIHP and the transition of LIHP-MCE enrollees to Medi-Cal is presented in: *Smooth Transitions into Medi-Cal: Ensuring Continuity of Coverage for Low Income Health Program Enrollees*.

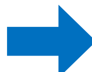
Background: LIHP-HCCI

The LIHP-HCCI program builds on a previous Coverage Initiative program undertaken by ten California counties from 2007-2010.[6] Each of the ten counties created a Coverage Initiative program to serve individuals with family incomes up to 200% of FPL who were ineligible for Medi-Cal. Under the 'Bridge to Reform' §1115 Waiver of 2010 which created the LIHP, all California counties had an option to provide services to individuals with incomes up to 200% FPL and receive 50% federal reimbursement for the services provided.

Four counties that had participated in the 2007-2010 Coverage Initiative program chose to operate LIHP-HCCI programs: Alameda, Contra Costa, Orange and Ventura. The remaining six counties that participated in the 2007-2010 Coverage Initiative program transitioned their enrollees to LIHP, but opted not to open their LIHP enrollment to new HCCI enrollees. All other counties chose not to participate in the LIHP-HCCI. LIHPs choosing to offer an HCCI program component had to ensure that LIHP-MCE enrollees would have priority over LIHP-HCCI enrollees.

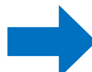
Exhibit 1. LIHP-HCCI enrollment by county as of December 2012

LIHP-HCCI Program Enrollment December 2012	
County	No. of Enrollees
Alameda	8,990
Contra Costa	2,120
Orange	9,745
Ventura	2,934
Total	23,789



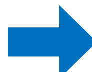
Four counties are enrolling new LIHP-HCCI participants and continue to serve enrollees from the past Coverage Initiative program.

Past Coverage Initiative program enrollees now being served by LIHP December 2012	
County	No. of Enrollees
Kern	414
Los Angeles[1]	185
San Diego	85
San Francisco	1,039
San Mateo	152
Santa Clara	711
Total	2,586



Six counties, which participated in the Coverage Initiative program from 2007-2010, transitioned enrollees to LIHP, but opted not to open their LIHP-HCCI program to new enrollees. LIHP-HCCI enrollment in these counties may decrease prior to 2014.

Total 26,375



Number of individuals with incomes above 133% FPL enrolled in LIHP in December 2012.

[1] Los Angeles County data are self-reported.

Update on LIHP-HCCI Enrollment

In December 2012, LIHP-HCCI enrollment nearly reached the total expected to transition to *Covered California* in 2014 (27,000). Exhibit 1 provides an overview of the current LIHP-HCCI programs and their enrollment as of December 2012. LIHP-HCCI enrollment is not expected to increase dramatically before the transition. In counties without active HCCI programs, enrollment will likely decrease as some enrollees experience income changes and older enrollees qualify for Medicare.

Covered California, The Health Insurance Exchange of California

California was one of the first states to develop a state-based health insurance exchange authorized by the ACA, which has been conditionally approved to operate by the U.S. Department of Health and Human Services. The exchange, named *Covered California*, is a virtual marketplace that allows citizens and lawfully residing immigrants, who do not have access to affordable employment-based coverage and are not eligible for Medi-Cal or other public coverage, to purchase subsidized health insurance if they earn up to 400% of FPL. *Covered California* health plans are also available to small employers through the Small Business Health Options Program (SHOP).[7]

The California Simulation of Insurance Markets (CalSIM) model predicts that 840,000 to 1.2 million individuals with family incomes below 400% FPL will purchase insurance offered through *Covered California* and receive income-based premium tax credits to subsidize the out-of-pocket cost of coverage in 2014.[8] While CalSIM estimates that 840,000 Californians with incomes up to 200% FPL will be eligible for premium tax credits, enrollment in *Covered California* is expected to range from 36 to 54% (between 300,000 and 450,000 individuals) in 2014.[9] The lower range of take-up represents the response if minimal outreach is performed while the upper range represents the response anticipated with targeted outreach and communications and a strong effort made to engage the newly eligible.

LIHP-HCCI Enrollees Qualify for Subsidized Health Coverage in *Covered California*

LIHP-HCCI enrollees are among those eligible for premium subsidies and cost-sharing reductions to lower their total cost of health care services. Premium contributions for this group may be as low as $40 per individual or $82 for a family of four according to the UC Berkeley Center for Labor Research and Education's Premium Calculator (Exhibit 2). For LIHP-HCCI enrollees, subsidized monthly premium contributions vary by family size and annual household income; the total out-of-pocket expenditures are limited for deductibles, co-payments and other cost sharing.

Paying for health services will not be completely new to the LIHP-HCCI enrollees, but the requirement to pay a monthly premium and also a share of the services will be a significant change. LIHP-HCCI programs have various cost structures and none charge a monthly premium for enrollment. The maximum annual cost sharing amount may not exceed 5% of family income. LIHP-HCCI enrollees with incomes above 150% FPL are those most likely to have experience with cost sharing for health services such as prescriptions, emergency room visits and outpatient visits. Preparing enrollees for the change in payment type

Exhibit 2. Expected costs of subsidized insurance plans in *Covered California* for LIHP-HCCI enrollees

	Single Individual	Family of Four
Federal Poverty Level	Up to 200%	Up to 200%
Annual Income	$15,870—22,900	$32,520-47,000
Monthly premium contribution	$40—120	$82—246
Annual limit on out of pocket costs*	$2,250	$4,500

*Annual limit applies to: deductibles, co-payments, and other cost sharing.
Source: http://laborcenter.berkeley.edu/healthpolicy/calculator/index.shtml

and frequency will be an important aspect of promoting a successful transition.

Other LIHP-HCCI enrollees will be income eligible for Medi-Cal

LIHP-HCCI enrollees have incomes above 133% and up to 200% of FPL. However, *Covered California*'s income eligibility for this group begins above 138% FPL. This means that some LIHP-HCCI enrollees will be eligible for the Medi-Cal expansion rather than subsidized coverage through *Covered California*.[10] Review of current enrollee income levels shows that approximately 90 percent, an estimated 27,000, of LIHP-HCCI enrollees will be income-eligible for *Covered California*.[11] A few LIHP-HCCI enrollees may be ineligible for subsidies in *Covered California* because their employer or a family member's employer offers coverage considered affordable under the ACA. However, employer decisions in late 2013 will drive what insurance coverage options are available to those enrollees.

Transition Planning for LIHP-HCCI Enrollees is Underway

The 'Bridge to Reform' §1115 Waiver Special Terms and Conditions require the development of a transition plan to move LIHP enrollees into new options for affordable coverage. Planning for the transition of LIHP-HCCI enrollees to *Covered California* is likely to be more complex than the LIHP to Medi-Cal transition because of new, streamlined income determination methods required by the ACA, the availability of tax credits and cost sharing reductions, and the need to choose a private health plan. During 2012, California focused primarily on planning for the transition of LIHP-MCE enrollees to Medi-Cal due to their large number (currently over 470,000) and the limited information that was available regarding *Covered California* health plans and the California Healthcare Eligibility Enrollment and Retention System (CalHEERS). More detailed planning for the *Covered California* transition is now underway. A summary of current transition plans for the LIHP-HCCI enrollees is provided below.

Communication and Outreach

Communication plans that have already been developed by the Department of Health Care Services (DHCS) and *Covered California* include:

- LIHP enrollees will receive notification that the LIHP will be ending December 31, 2013. A general notice will be provided and include information about *Covered California* and the Medi-Cal expansion.
- A LIHP Transition Planning Workgroup has been initiated by DHCS to involve stakeholders in the process of developing communication and outreach materials, as well as providing insight and feedback on other Medi-Cal and Exchange related policy and operational decisions. Group members include advocates, community-based organizations, LIHPs, as well as key DHCS departments and consultants.
- *Covered California* is establishing plans for extensive outreach and marketing to California residents with incomes up to 400% of FPL, which will also reach LIHP enrollees.

Promoting Enrollment

To facilitate the transition to new coverage options in 2014, LIHP-HCCI data from the Medi-Cal Eligibility Data System (MEDS) will be provided to *Covered California* for targeted outreach to LIHP-HCCI enrollees.[12] *Covered California* customer service representatives will assist HCCI enrollees in completing the eligibility determination process through CalHEERS. Based on the outcome, HCCI enrollees will be incorporated into transition activities for *Covered California* or follow steps to be enrolled in Medi–Cal. CalHEERS will also determine eligibility for subsidies and the premium tax credit amount. CalHEERS utilizes Modified Adjusted Gross Income (MAGI) guidelines to assess eligibility, a new requirement created by the ACA.

Recommendations to Promote a Smooth Transition

A successful LIHP-HCCI transition depends on active engagement of LIHP enrollees in choosing appropriate subsidy assistance levels and choosing a health plan. Recommendations below describe methods to enhance engagement and promote purchasing of health insurance plans through *Covered California*.

Recommendation 1: Collaborate with LIHPs for Communication and Outreach Activities

Covered California has the opportunity to promote enrollment by working closely with the counties serving the majority if LIHP-HCCI enrollees: Ninety-two percent of LIHP-HCCI enrollees are found within Alameda, Contra Costa, Orange, San Francisco and Ventura counties. The

following strategies could be incorporated into *Covered California* communication and outreach in these counties:

- Develop joint communications with the LIHPs so that current LIHP-HCCI enrollees hear about *Covered California* from the LIHP, an organization they associate with their personal health care. Examples of joint communications to enhance enrollment include:
  - The first targeted outreach mailing explaining that the LIHP coverage is ending and how to pursue coverage within *Covered California* beginning in October 2013 during open enrollment.
  - A letter to LIHP providers about the transition and a Frequently Asked Questions document to support the providers' ability to answer questions from LIHP enrollees.
- Engage LIHPs in reaching out to those previously enrolled in LIHP or those on LIHP waiting lists, as these individuals would not be included in mailings to current enrollees about *Covered California* or Medi-Cal.
- Prepare LIHPs to be the point-of-contact for questions until October 2013 when *Covered California* can enroll new beneficiaries. After October 1st, the LIHP enrollees can contact *Covered California* directly and talk to Service Center staff.
- Create a special toll-free number leading to Service Center staff knowledgeable about LIHP, and provide notice that because of current or past eligibility for LIHP, they are likely to be eligible for subsidies.
- Provide enrollment assisters in the LIHP-HCCI counties with information so they can answer questions and guide previous LIHP enrollees into appropriate programs.

Covered California could also consider working closely with counties not currently operating a LIHP-HCCI program, but operating other county-based health coverage programs. A share of enrollees from these county programs will be eligible for *Covered California* and some may also qualify for subsidies. Collaborating on communication and outreach may offer *Covered California* an opportunity to reach a larger group of beneficiaries who may not have had the opportunity to be enrolled in a LIHP.

Recommendation 2: Utilize LIHP Data for the Enrollment Process and Provide Personalized Follow-up

Covered California could build on the current plans for targeted outreach to LIHP-HCCI enrollees by using the same information to pre-fill *Covered California* enrollment data fields. This will reduce the number of steps required to enroll in coverage and allow enrollees to focus on choosing a health plan and understanding premium tax credits. Making this information available to Service Center staff assisting with enrollment will also speed the enrollment process.

Given the concentration of HCCI participants in a small number of counties, *Covered California* should promote enrollment through preparing specialized assisters in the counties with HCCI enrollees. Specialized assisters could perform follow-up phone calls to gather additional information and support LIHP enrollees in enrolling in new coverage.

Conclusion

LIHP-HCCI enrollees will need to be engaged in the process of transition from LIHP to *Covered California.* Through collaborative communication, timely facilitation of the enrollment process and providing additional support to enrollees, *Covered California* can enhance enrollment of the eligible LIHP-HCCI participants.

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Lytle EC, Roby DH, Lucia L, Jacobs K, Cabezas L, and Pourat N. *Promoting Enrollment of Low Income Health Program Participants in Covered California.* Los Angeles, CA: UCLA Center for Health Policy Research, April 2013.

Notes

1. Analysis of the UCB-UCLA California Simulation of Insurance Markets (CalSIM) version 1.8 model.
2. The Governor's budget introduces the potential for LIHPs and Medi-Cal Managed Care Plans to offer bridge plans within *Covered California.* This would not extend the current Low Income Health Program, so a transition by LIHP enrollees to *Covered California* will be required. http://www.ebudget.ca.gov/pdf/BudgetSummary/HealthCareReform.pdf
3. The County Medical Services Program (CMSP) operates LIHPs in 35 counties while all other LIHPs are administered by single counties.
4. UCLA analysis of Low Income Health Program enrollment data as of December 31, 2012. LIHP enrollment data updates available at: http://healthpolicy.ucla.edu/programs/health-economics/projects/coverage-initiative/blog/default.aspx
5. Estimate based on LIHP-HCCI enrollment trends from the first twelve months of the LIHP. Data source: UCLA LIHP Evaluation Data from coverageinitiative.ucla.edu.
6. The original Health Care Coverage Initiative program was part of California's 2005-2010 §1115 Safety Net Care Financing Demonstration Waiver.
7. Small employers are those with 50 employees or fewer through 2015 or 100 employees or fewer beginning in 2016; Unaffordable coverage is defined as an out-of-pocket premium contribution of more than 9.5% of household income for single coverage; California residents must be citizens or legal residents to purchase health insurance within *Covered California*.
8. Analysis of the UCB-UCLA California Simulation of Insurance Markets (CalSIM) version 1.8 model.
9. Enrollment by this population is expected to grow and by 2019, 68-86% (630,000 to 900,000 individuals) of those with incomes over 138% of FPL and up to 200% of FPL are expected to enroll in *Covered California*. Enrollment estimates based on analysis of the UCB-UCLA California Simulation of Insurance Markets (CalSIM) version 1.8 model.
10. The Affordable Care Act introduced new Medi-Cal eligibility guidelines: a five-percent income disregard will be applied to all new Medi-Cal applicants. The income disregard raises the effective income eligibility level for Medi-Cal from 133% to 138% of FPL.
11. Estimate based on LIHP enrollment trends from the first 12 months of program operation.
12. Planned data transfer processes are described in the Policy Note accompanying this report: *Smooth Transitions into Medi-Cal: Ensuring Continuity of Coverage for Low Income Health Program Enrollees*.

- Health Affairs Blog - http://healthaffairs.org/blog -

Implementing Health Reform: Proposed Regulations for Exchange "Navigators"

Posted By Timothy Jost On April 4, 2013 @ 10:45 am In Access,All Categories,Blog,Consumers,Health Law,Health Reform,Personal Experience,Policy,Politics,Public Opinion,Reform,States | No Comments

On April 3, 2013, the Department of Health and Human Services released proposed regulations [1]establishing standards to govern navigators and non-navigator assisters in the federally facilitated exchange as well as clarifying standards on the role of navigators and on who can serve as a navigator in all exchanges.

The controversial navigator program

The navigator program has proven surprisingly controversial. The Affordable Care Act's navigator program was modeled after the successful State Health Insurance Assistance Program (SHIP) [2] which has offered assistance to Medicare beneficiaries trying to figure out the complexities of Medicare Advantage and Prescription Drug Plan offerings. The original concept of the ACA navigator program was that exchanges would give grants to community and small business organizations to educate and provide unbiased information to individuals and small employers to help them navigate the new health insurance marketplace and enroll in health insurance plans. Navigators will be particularly helpful to millions of uninsured Americans who will be purchasing health insurance on their own for the first time and who will be eligible either for Medicaid or for premium assistance tax credits. Many of these consumers will be unfamiliar with health insurance or not literate in English. HHS has also created a non-navigator consumer assistance program for states without federal exchanges based on an understanding that consumers in those states will need help, but that navigator programs under the ACA cannot be funded by federal establishment grants and that exchanges will not have their own funding for navigators until their exchanges are up and running.

The navigator program has become surprisingly controversial. Insurance agents and brokers have seen it as threatening their territory. Agents seem to be concerned that if navigators help consumers enroll in health insurance plans, agents will lose the commissions to which they are entitled when they themselves market insurance products. Agents are also concerned that if unqualified navigators or other assisters are allowed to recommend insurance products to consumers, consumers may purchase products that do not meet their needs. Agent organizations have been lobbying state legislatures across the country to license navigators and in so doing to place barriers in the path of entities or individuals that might consider becoming navigators while also limiting the activities in which navigators can engage. Responding to lobbying by politically powerful agent organizations, states that have shown little interest in participating in any way in the implementation of the ACA have been enacting legislation to regulate the navigator program. Many of these states will have federal exchanges. The proposed regulations lay down standards for the navigator program in the federal exchange which will preempt more restrictive state standards. It also clarifies the extent to which states can license navigators in both the state and federal exchanges.

The preamble to the proposal explains the role of the navigator. Navigators will not make eligibility decisions or select qualified health plans (QHPs) for consumers, but will rather help them through the enrollment process. In the words of the preamble, "Navigators may play an important role in facilitating a consumer's enrollment in a QHP by providing fair, impartial, and accurate information that assists consumers with submitting the eligibility application, clarifying the distinctions among QHPs, and helping qualified individuals make informed decisions during the health plan selection process." Navigators are not agents—they cannot legally solicit, negotiate, and sell insurance contracts and receive a commission—but they do have a definite role to play in assisting and informing consumers in the insurance purchase process, and are

not mere observers of this process.

Non-navigator assister programs

The proposal clarifies again that states without federal exchanges are expected to establish not only navigator programs but also "non-navigator assistance programs," which have sometimes been referred to as "in-person assistance programs." This program will play a vital role during 2013, as consumers will desperately need help making sense of the insurance marketplace as it comes on line, but states are prohibited by the ACA from using establishment grants to create navigator programs, and will not be able to pay for navigators on their own until they are up and running and have their own funds to pay for them. States can, however, use establishment funds to create assister programs. (They can also use establishment grant funds to cover navigator program administrative costs). It is expected that states that establish state-based exchanges, as well as states that establish state consumer assistance partnership exchanges, will establish non-navigator community assistance programs that will continue to help consumers at least until their navigator programs are up and running.

While navigator programs are grant programs, non-navigator assistance programs can be operated through contracts, direct hiring, or grants. In federally facilitated exchanges other than partnership exchanges, the federal government will make grants to navigator programs and does not expect to have non-navigator assisters. The proposed regulation generally holds assisters to the same requirements as navigators.

The proposed rule begins by proposing an amendment to an existing rule to clarify that "any Navigator licensing, certification, or other standards prescribed by the state or Exchange must not prevent the application of the provisions of Title I of the Affordable Care Act." An amendment is also proposed to the existing exchange regulations to strengthen the conflict of interest standards governing navigators. These amended regulations apply to all exchanges—state, partnership, and fully federal.

Preemption of state regulation

Earlier exchange rules [3] had stated that navigators will have to meet licensure or certification standards established by the states or exchanges. The amended rule clarifies that state licensure or certification rules must not prevent the application of ACA navigator requirements. States may not require navigators to be licensed as agents or to carry errors and omissions insurance like agents. Although the amended rule could be clearer, it presumably has implications for states that are considering background check, fingerprinting, surety bond, or other requirements that could cumulatively make attaining navigator status so burdensome that the program will not be viable. Severe state limitations on the kind of advice and guidance navigators can offer consumers should also be preempted.

Conflict-of-interest standards

The proposed rule further provides details on conflict-of-interest standards and standards relating to training, certification, and recertification for navigators and non-navigators in federal and partnership exchanges. These standards include details on certification, registration, training, and examination of navigators and assisters. They also establish standards to ensure meaningful access to services for individuals with limited English proficiency and people with disabilities for navigators and assisters in federal and partnership exchanges. While these standards do not explicitly apply to state-based exchange navigator programs, they do apply to state assister programs funded through federal exchange establishment grants and are proposed as a "useful model" for state-funded programs. The proposed rule does not apply to certified application counselors, a new category established by the recent proposed rule on Medicaid eligibility http://www.gpo.gov/fdsys/pkg/FR-2013-01-22/pdf/2013-00659.pdf, but comments are requested on whether they should apply to this category of assisters as well.

The conflict of interest prohibition found in the original rule is expanded. Under existing rules

navigators may not be health insurance issuers, subsidiaries of issuers, associations of insurers or insurer lobbyists, or receive direct or indirect consideration for insurers, including trailer commissions for past sales. The proposed rule expands prohibited relationships to include relationships with stop loss issuers or subsidiaries of stop loss issuers, or consideration from stop loss issuers. There has been increasing concern that insurers may tempt small employers to forego the purchase of group insurance and rather to "self-insure" purchasing generous stop-loss insurance to limit their risk, thus opting out of many of the ACA's small group market protections. The new prohibition will limit the ability of stop loss insurers to use navigators to steer small businesses in this direction. Navigator conflict-of-interest standards would also apply to non-navigator assisters, including state non-navigator assisters funded by federal establishment grants.

Navigators will be required to submit to the exchange an attestation that they are free from conflicts of interest and a written plan to ensure that they will remain free from conflicts of interest. Navigators must provide consumers with information on the full range of QHP options and insurer affordability programs. The proposed rule recognizes, however, that conflicts of interest may potentially exist, and these must be disclosed. Agents or brokers that serve as navigators may not sell health or stop loss insurance, but may sell other lines of insurance. If they do so, this must be disclosed. This exception is troublesome to the extent that an agent could be a navigator but be allowed to sell (with disclosure) complementary lines of insurance coverage (such as adult vision or dental or long-term care) or non-health lines of insurance available from insurers that also market health insurance in the exchange. Navigators and their staff members would also have to disclose any past relationships with health or stop loss insurers in the past five years, any insurer relationships with spouses or domestic partners, and any existing or anticipated financial, business, or contractual relationships with insurers.

Training and certification standards

The proposed rule also establishes training standards for entities and individuals carrying out navigator standards. HHS had earlier proposed that navigators and assisters "be trained regarding QHP options, insurance affordability programs, eligibility, and benefits rules and regulations governing all insurance affordability programs operated in the state, as implemented in the state, prior to providing such assistance." The proposed rule specifies that navigators and non-navigator assisters in federal exchanges and federally funded non-navigator assisters in state exchanges must receive up to 30 hours of training. These personnel must register with the exchange, be certified as having received the necessary training, and pass a HHS-approved exam. The rule specifies in detail the topics that must be covered by the training program, including privacy and security issues. Navigators must receive continuing education and be recertified on at least an annual basis. Navigator and non-navigator assisters must be trained to assist with SHOP exchange as well as individual exchange issues, although in general a navigator may refer a consumer to other exchange resources where an issue arises beyond the navigator's competence.

While the training and certification standards section of the proposed rule does not clearly refer to preemption, they do set out specific requirements for navigators in the federal exchange, navigator and non-navigator assisters in partnership exchanges, and non-navigator assisters in state exchanges funded by federal funds. Although states may license or certify navigators or assisters, presumably state education, training, or examination requirements more burdensome or materially different from those prescribed in the federal rule will be preempted as preventing the application of the federal rule.

Cultural and linguistic appropriateness and disability discrimination standards

Finally, the proposed rule addresses requirements for providing culturally and linguistically appropriate services, as well as services to the disabled. The proposed rule would require navigators to be familiar with the racial, ethnic, and cultural groups in their area, have access to oral interpretation and written translations of appropriate documents in non-English languages without cost to the consumer, to rely on family or friends for interpreters only when that is the consumers preferred alternative, and to have access to telephone interpretive services. Non-

English speakers must be informed of the availability of these services. Programs must implement strategies to recruit and promote a staff that is representative of the demographic characteristics of the community. Auxiliary aids and services must also be available without cost to ensure that services are available to people with disabilities. Federally facilitated exchanges and state partnership exchanges must monitor compliance with navigator program requirements.

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[2] State Health Insurance Assistance Program (SHIP): **http://healthreformgps.org/resources/state-health-insurance-exchange-navigators/**
[3] Earlier exchange rules: **http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf**

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I. Executive Summary

Background

In March 2010, the U.S. Congress passed the Patient Protection and Affordable Care Act (ACA), a sweeping piece of legislation designed to overhaul the country's health care system and extend health insurance to millions of uninsured Americans. The law includes numerous provisions that aim to accomplish this goal. One way in which the ACA increases access to commercial health insurance coverage is by restricting insurers from denying coverage, excluding individuals with pre-existing conditions, and varying premiums based on an individual's health status. To minimize the adverse selection that could result from certain provisions, the ACA includes other provisions, such as premium and cost-sharing subsidies administered via a Health Benefits Exchange (HBE) and an individual tax penalty for those who do not purchase sufficiently valuable health insurance coverage. These provisions aim to increase overall participation in health insurance plans. The ACA includes additional provisions to expand health coverage to U.S. residents, such as the option for states to expand Medicaid to nearly all adults below 138 percent of FPL, a requirement for all large employers to offer health insurance to full-time employees or face a penalty, and a tax credit to small employers to offset the cost of insurance and thus incentivize them to offer coverage. [1]

Our baseline estimates indicate that of the 52.4 million individuals who would have been expected to otherwise lack health insurance coverage in the absence of the ACA, 32.4 million will obtain coverage, assuming all ACA provisions were fully implemented and presented in 2014, and assuming all states expand Medicaid.[2] This includes 10.4 million individuals who gain coverage through the individual exchange, 0.4 million individuals who gain private non-group coverage, 2.2 million individuals who gain coverage in a Small Business Health Options Program (SHOP) Exchange, 5.4 million individuals who gain other employer coverage, and 14.0 million individuals who gain coverage through Medicaid expansion, if all states participate, which may not occur. Given that all states will not participate in the Medicaid expansion, state-level estimates comparing number of uninsured under expansion versus no expansion are presented in ***Figure S-1*** and ***Figure S-2***.

Project Scope

The SOA's research objective is to provide guidance to state exchange officials and administrators, federal officials and administrators, and actuaries assisting states and health plans. The goal of the project is to estimate the morbidity and/or cost for newly insured individuals in the individual market (and to some degree, the small group exchange) relative to the morbidity and/or cost for the current commercially insured population. This analysis will primarily focus on the individual, non-group market. In order to plan for the impact that these currently uninsured individuals will have on the health insurance markets, it is important to understand their costs relative to the costs for people already enrolled, for whom many health insurers have experience and data.

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[1] The ACA provides the option for states to expand Medicaid to 133% of FPL and includes a provision to disregard 5% income of a family's income for eligibility determination, which effectively increases eligibility to 138% of FPL.
[2] The 32.4 million estimate is an overestimate, as many states have indicated that they will not participate in Medicaid expansion.

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The key research questions explored in this analysis include:

- What is the anticipated enrollment for the currently uninsured under the ACA?
- For the newly insured, what is their relative morbidity and what could reasonably be expected for relative costs, compared to the currently insured?
- What will be the general impact of the newly insured on the overall post-reform health care industry and insurance market, in terms of supply and demand for health care services and insurance carriers?
- How will health care costs for the newly insured differ by state?
- What will be the relative health status and cost for individuals who remain uninsured and how will this vary by state?
- If states expand Medicaid under the ACA, what is the impact on Medicaid costs and enrollment?

Note that the ACA's affect on *premium* is not modeled in this research; rather, *long-term relative claims cost* is modeled. Many aspects of the ACA will affect premiums, including changing benefit designs, new taxes and assessments, federal risk mitigation programs, minimum loss ratio rules, rate review rules, and premium subsidies.

Research Model Used

Our research estimates are made using The Lewin Group Health Benefits Simulation Model (HBSM). The HBSM is a micro-simulation model of the U.S. health care system. HBSM is a fully integrated platform for simulating policies ranging from narrowly defined insurance market regulations to Medicaid coverage expansions and broad-based reforms involving multiple programs such as the ACA. It was developed in 1989 to simulate the wave of reform proposals that culminated in the health reform proposal introduced by President Clinton in 1993. The model was used by the U.S. Bipartisan Commission on Comprehensive Health Care (the Pepper Commission) in 1990 and has been in almost constant use since then by The Lewin Group at the state and national levels. The Lewin Group has been using this model since 2010 to assist clients with ACA planning, strategies and actions. The SOA retained Optum, who chose to use the HBSM model and engage The Lewin Group to conduct this research study. Optum is the parent company of The Lewin Group. Randy Haught and John Ahrens, authors of this report, are employees of Optum. However, the authors' analyses and interpretations are based upon their own professional expertise and are offered within the scope of work they were asked to perform by the SOA. Their findings or conclusions do not necessarily represent a position of Optum or Lewin.

The HBSM is explained in greater detail within the Technical Notes and in Appendix A and B. The reader is encouraged to read and understand the model and assumptions prior to using the model results for analysis.

The HBSM model outputs are based on expected cost results in 2014, but assuming full implementation of the 2016 penalties (when full penalties apply) and also assuming that ultimate enrollment in the various programs and the Exchanges is completed right away. Reality will likely result in a lag in enrollment shifts, such that not all people who are modeled

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to ultimately take coverage will do so in immediately in 2014, as presented in this research. Observations from prior Medicaid expansions show that it may take three to four years to reach an ultimate enrollment state. In addition, this research does not reflect that newly insured individuals may have a pent-up demand for services due to previously unmet health care needs, and further does not reflect that the earliest new enrollees may differ from the average risk group that will ultimately enroll. Therefore, each user of this report will need to make their own assumptions for each state with respect to how the initial years' (2014 and 2015) enrollment and distribution of risks may occur, as well as the appropriateness of the model for 2016 and subsequent years. In order to assist the practitioner in modifying the results, Excel worksheets are provided for each state to facilitate the process.

Key Findings

Key findings are summarized in ***Figure S-1*** and ***Figure S-2*** by state. Due to the changing status of participation in the Medicaid expansion for individual states, ***Figure S-1*** shows the percent uninsured, non-group enrollment, and non-group costs pre- and post- ACA for each state assuming that all states expand Medicaid, resulting in many of the uninsured enrolling in Medicaid. ***Figure S-***2 shows these same results for each state, but assumes that none of the states expand Medicaid. The reader can select the appropriate table based on the state's current Medicaid participation status. The three findings summarized below assume Medicaid expansion in all states. Although the costs shown in the tables are at projected 2014 levels, the actual enrollment and percentage increases in costs reflect an "ultimate" or "steady-state" environment, which we assume corresponds to about 2016 or 2017 (after three years of exchanges). Therefore, mitigating strategies being considered in 2013 for 2014 and 2015 (for example, some states are considering transitioning state high risk pools gradually) are not reflected in this model. The research models the long-term likely scenario when high risk pools have been fully transitioned into the market.

Finding 1: After three years of exchanges and insurer restrictions, the percentage of uninsured nationally will decrease from 16.6 percent to between 6.8 and 6.6 percent, compared to pre-ACA projections.

In the first section of ***Figure S-1***, estimates are shown for the percentage of all individuals uninsured in absence of the ACA and compared to two estimates of the percentage of all individuals uninsured in under the ACA, assuming full implementation and presented in 2014 dollars and population counts. Note that the counts are annual equivalents so that an individual who is uninsured for three months would count as 0.25 uninsured. This approach can result in differences with other counts of the uninsured which might be based on a snap shot on a given date, or count someone who is uninsured at any time in a year.

One of the key findings of our analysis is that the impact of the ACA on reducing the number of uninsured will vary substantially across states. Some of the factors that may explain these differences include: proportion of population that is uninsured prior to the ACA; portion of the uninsured below 400 percent of FPL, which is based in part on current Medicaid eligibility levels in the state; and average non-group costs.

To provide a range of results, the percentage of uninsured are simulated under two models: a price "elasticity" model and a "utility" function model. The elasticity model simulates the

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decision to take coverage based upon the change in the net cost of coverage to the individual under reform, a decision which varies by demographic characteristics of the individual. The utility function models an amount that someone is willing to pay to be protected against the risk of going without insurance; they choose coverage if the cost is less than that figure.

Finding 2: Under the ACA, the individual non-group market will grow 115 percent, from 11.9 million to 25.6 million lives; 80 percent of that enrollment will be in the Exchanges.

The middle section of ***Figure S-1*** provides estimates for the number of non-group individuals covered pre-ACA compared to the number of those expected to be covered post-ACA; this is shown under the elasticity model. The percentage of non-group individuals in the Exchanges is shown as well. We model that 80 percent of non-group coverage will be through the Exchanges, since subsidies will only be available for coverage purchased through the Exchanges. Our model assumes that people purchasing non-group coverage who are eligible for subsidies will purchase through the Exchanges. Much of the increase in coverage is a result of the premium and benefit subsidies for lower income individuals, many of who will select the "silver" benefit tier since that is the tier for which benefit subsidies are tied.

Finding 3: The non-group cost per member per month will increase 32 percent under ACA, compared to pre-ACA projections.

In the last section of ***Figure S-1***, the average non-group allowed per member per month cost, excluding those in high risk pools (state-run pools that existed pre-ACA and federally funded state pools under ACA), is shown in absence of the ACA; these costs reflect the "underwritten" risk in most states.[3] The percentage increase between pre- and post-ACA estimates is shown as well. The post-ACA figures include the impact of a) high risk pool members, b) employers dropping group coverage, and c) increased morbidity from selection by those currently uninsured who now purchase coverage. The results of this analysis indicate that there will be significant variation across states in the impact of the ACA on average cost in the non-group market. These estimates come from ***Figure 5*** of the state-specific tables. Since the populations before and after ACA may be significantly different, ***Figure 6A*** shows the increase by age bracket. States that show a decrease in average costs under the ACA are primarily those that currently use community rating in the non-group market. The reduction in average costs for these states reflects the younger and healthier individuals that will enroll due to the reduced cost from the premium subsidies.

Our analysis also indicates that while high risk pools generally have few enrollees, the cost per individual is very high. Movement of the high risk pool individuals into the non-group Exchange will generally create a significant increase in cost. However, it can be reasonably argued that proportionately more uninsured individuals will have similar risks in states that had relatively small high risk pools. The reader is encouraged to further examine this issue.

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[3] Our analysis assumes that both the State and Federal High Risk Pools will be rolled into the exchanges at some point in time. However, individual states may decide not to transition its state high risk pool enrollees in 2014 and phase this transition in over time. Reader should refer to their individual state's plan. For example, Maryland is planning to transition high risk pool enrollees into the exchange over time.

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Figure S-1. Summary of "Ultimate" Findings- Assuming All States Expand Medicaid

State	% Uninsured Pre-ACA	% Uninsured Post-ACA Elasticity	% Uninsured Post-ACA Utility	Size of Non-Group Pre-ACA	Size of Non-Group Post-ACA	% of Non-Group in Exchange	Average Non-Group PMPM Pre-ACA	Average Non-Group PMPM Post-ACA	% Change in Non-Group PMPM
Alabama	14.7%	4.9%	4.2%	117,257	295,633	86.8%	$263	$422	60.3%
Alaska	20.6%	8.5%	8.3%	22,702	62,501	83.8%	$436	$520	19.2%
Arizona	21.1%	12.0%	12.1%	250,488	570,681	81.5%	$290	$355	22.2%
Arkansas	18.1%	6.0%	4.9%	112,882	233,527	82.7%	$238	$335	40.9%
California	18.2%	8.4%	8.1%	1,789,865	3,163,015	72.4%	$260	$420	61.6%
Colorado	18.0%	7.9%	7.5%	293,851	502,554	75.7%	$262	$365	39.1%
Connecticut	12.7%	6.0%	6.0%	126,997	255,216	76.7%	$399	$514	28.8%
Delaware	9.5%	4.9%	4.9%	25,902	56,946	80.8%	$380	$491	29.3%
District of Columbia	12.3%	5.7%	5.5%	25,343	41,271	76.4%	$348	$528	51.9%
Florida	19.6%	8.3%	8.0%	843,935	1,684,727	79.4%	$313	$396	26.5%
Georgia	18.2%	6.9%	6.6%	349,454	762,955	81.6%	$310	$396	27.6%
Hawaii	8.0%	3.8%	3.9%	26,584	73,534	83.8%	$374	$456	21.9%
Idaho	16.6%	5.8%	6.1%	98,954	186,187	77.3%	$211	$343	62.2%
Illinois	13.1%	5.9%	5.6%	471,343	978,648	80.1%	$304	$459	50.8%
Indiana	14.3%	5.2%	4.8%	178,442	463,393	88.0%	$272	$455	67.6%
Iowa	13.2%	4.8%	5.0%	147,357	267,001	77.1%	$350	$384	9.7%
Kansas	16.6%	6.6%	6.3%	151,303	254,839	81.3%	$306	$364	18.9%
Kentucky	16.7%	5.6%	5.3%	143,620	346,334	84.3%	$297	$398	34.1%
Louisiana	15.7%	4.9%	4.6%	166,093	335,015	78.5%	$346	$444	28.6%
Maine	13.9%	5.4%	6.0%	43,870	121,784	84.3%	$468	$487	4.1%
Maryland	13.1%	6.0%	5.8%	184,809	386,491	78.4%	$284	$473	66.6%
Massachusetts	8.5%	4.9%	5.6%	178,053	362,583	75.7%	$519	$453	-12.8%
Michigan	12.2%	4.5%	4.4%	307,935	699,656	86.1%	$321	$404	25.8%
Minnesota	13.2%	4.9%	5.5%	247,752	524,708	82.1%	$356	$424	18.9%
Mississippi	18.2%	5.3%	4.7%	103,368	214,209	86.8%	$291	$417	43.2%
Missouri	17.4%	5.7%	5.2%	226,603	491,027	83.1%	$238	$378	58.8%
Montana	20.6%	7.7%	7.2%	64,363	116,419	84.3%	$331	$397	20.1%
Nebraska	14.3%	5.5%	5.5%	97,872	170,822	81.7%	$342	$448	30.8%
Nevada	20.4%	8.2%	8.6%	99,860	260,813	79.2%	$278	$359	29.2%
New Hampshire	12.2%	4.6%	5.4%	50,189	112,728	78.4%	$339	$464	36.8%
New Jersey	16.9%	7.4%	8.4%	272,731	724,548	76.5%	$481	$474	-1.4%
New Mexico	22.9%	8.8%	8.9%	42,890	173,704	89.6%	$291	$392	34.9%
New York	12.8%	6.0%	6.9%	450,240	1,615,925	84.3%	$619	$533	-13.9%
North Carolina	18.2%	6.6%	6.4%	402,677	855,147	81.7%	$361	$409	13.5%
North Dakota	14.1%	5.9%	6.2%	51,468	74,774	80.6%	$326	$353	8.4%
Ohio	13.3%	5.0%	3.6%	414,914	805,282	80.9%	$223	$403	80.9%
Oklahoma	16.9%	6.3%	5.6%	134,305	290,180	84.1%	$275	$355	29.3%
Oregon	21.0%	7.2%	8.1%	169,412	435,206	82.7%	$335	$383	14.3%
Pennsylvania	11.2%	4.5%	4.0%	488,341	863,565	80.5%	$356	$455	28.0%
Rhode Island	14.9%	6.6%	7.1%	42,842	91,031	79.4%	$587	$548	-6.6%
South Carolina	17.3%	5.9%	5.5%	161,496	367,909	87.9%	$309	$423	36.8%
South Dakota	14.3%	5.3%	5.3%	52,775	85,094	79.9%	$318	$410	29.0%
Tennessee	15.0%	5.7%	4.9%	281,421	532,091	81.7%	$260	$380	46.4%
Texas	27.1%	10.5%	10.2%	888,205	2,448,638	83.4%	$249	$333	33.8%
Utah	15.5%	6.4%	6.3%	163,811	300,123	75.9%	$245	$314	28.4%
Vermont	13.6%	6.7%	7.3%	15,376	56,986	87.8%	$587	$514	-12.5%
Virginia	15.1%	6.4%	6.1%	328,880	628,457	79.6%	$306	$393	28.4%
Washington	15.6%	6.2%	6.6%	344,620	665,284	74.2%	$314	$357	13.7%
West Virginia	15.6%	4.6%	4.0%	33,191	113,534	89.5%	$347	$469	35.3%
Wisconsin	10.4%	4.8%	4.5%	215,407	442,020	85.1%	$258	$464	80.0%
Wyoming	16.4%	6.0%	6.2%	29,076	54,265	82.6%	$434	$571	31.6%
National	**16.6%**	**6.8%**	**6.7%**	**11,931,125**	**25,618,984**	**80.4%**	**$314**	**$413**	**31.5%**

Assumes all ACA provisions are implemented by 2014, even provisions effective later. Results are similar to what would be expected by 2017, but presented in 2014 dollars and counts. Average non-group PMPM includes total expected claims costs for members but excludes other important items that are needed to model premium, including admin, taxes, and subsidies. States with large high risk pools may consider transitioning these enrollees into the exchange over a longer time frame in order to mitigate cost increases.

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Figure S-2. Summary of "Ultimate" Findings- Assuming No States Expand Medicaid

State	% Uninsured Pre-ACA	% Uninsured Post-ACA	Size of Non-Group Pre-ACA	Size of Non-Group Post-ACA	% of Non-Group in Exchange	Average Non-Group PMPM Pre-ACA	Average Non-Group PMPM Post-ACA	% Change in Non-Group PMPM
Alabama	14.7%	8.4%	117,257	378,573	89.5%	$263	$416	58.2%
Alaska	20.6%	11.4%	22,702	74,109	86.3%	$436	$497	13.9%
Arizona	21.1%	12.4%	250,488	577,725	81.8%	$290	$367	26.3%
Arkansas	18.1%	10.0%	112,882	295,130	86.2%	$238	$334	40.4%
California	18.2%	11.3%	1,789,865	3,653,808	76.3%	$260	$403	55.2%
Colorado	18.0%	10.6%	293,851	595,460	79.4%	$262	$354	34.8%
Connecticut	12.7%	8.0%	126,997	285,552	79.0%	$399	$491	23.0%
Delaware	9.5%	4.9%	25,902	63,450	82.7%	$380	$484	27.4%
District of Columbia	12.3%	8.6%	25,343	46,803	78.7%	$348	$497	43.1%
Florida	19.6%	11.4%	843,935	2,002,920	83.0%	$313	$382	22.1%
Georgia	18.2%	10.7%	349,454	934,891	85.1%	$310	$383	23.2%
Hawaii	8.0%	4.9%	26,584	83,153	85.5%	$374	$421	12.6%
Idaho	16.6%	8.3%	98,954	224,042	81.1%	$211	$342	61.8%
Illinois	13.1%	8.2%	471,343	1,102,590	82.1%	$304	$447	46.9%
Indiana	14.3%	8.0%	178,442	560,081	89.9%	$272	$452	66.4%
Iowa	13.2%	7.0%	147,357	319,447	80.6%	$350	$369	5.5%
Kansas	16.6%	9.4%	151,303	309,683	84.6%	$306	$353	15.5%
Kentucky	16.7%	9.1%	143,620	431,290	87.5%	$297	$393	32.2%
Louisiana	15.7%	8.7%	166,093	418,914	82.4%	$346	$459	32.7%
Maine	13.9%	7.3%	43,870	137,524	86.0%	$468	$490	4.7%
Maryland	13.1%	8.1%	184,809	440,563	80.9%	$284	$459	61.4%
Massachusetts	8.5%	5.0%	178,053	373,953	76.4%	$519	$478	-8.0%
Michigan	12.2%	6.5%	307,935	854,242	88.4%	$321	$399	24.3%
Minnesota	13.2%	6.9%	247,752	613,391	84.4%	$356	$413	16.1%
Mississippi	18.2%	10.4%	103,368	278,048	89.7%	$291	$419	43.9%
Missouri	17.4%	9.5%	226,603	613,937	86.2%	$238	$370	55.8%
Montana	20.6%	11.0%	64,363	143,119	87.1%	$331	$389	17.8%
Nebraska	14.3%	7.5%	97,872	205,753	84.8%	$342	$430	25.5%
Nevada	20.4%	11.3%	99,860	303,175	82.9%	$278	$346	24.5%
New Hampshire	12.2%	6.2%	50,189	131,811	81.5%	$339	$471	38.8%
New Jersey	16.9%	10.0%	272,731	776,556	78.8%	$481	$492	2.2%
New Mexico	22.9%	12.1%	42,890	214,044	91.9%	$291	$373	28.2%
New York	12.8%	6.2%	450,240	1,708,252	85.2%	$619	$556	-10.1%
North Carolina	18.2%	10.2%	402,677	1,043,777	85.1%	$361	$392	8.7%
North Dakota	14.1%	7.5%	51,468	88,358	83.4%	$326	$353	8.3%
Ohio	13.3%	7.8%	414,914	1,000,301	84.1%	$223	$406	82.1%
Oklahoma	16.9%	9.1%	134,305	358,001	87.0%	$275	$358	30.3%
Oregon	21.0%	11.0%	169,412	522,363	86.1%	$335	$378	12.8%
Pennsylvania	11.2%	6.5%	488,341	1,054,988	83.8%	$356	$443	24.5%
Rhode Island	14.9%	9.0%	42,842	102,090	81.4%	$587	$549	-6.4%
South Carolina	17.3%	9.4%	161,496	455,872	90.0%	$309	$433	39.9%
South Dakota	14.3%	7.5%	52,775	101,767	83.1%	$318	$434	36.6%
Tennessee	15.0%	8.6%	281,421	654,610	85.0%	$260	$372	43.4%
Texas	27.1%	14.9%	888,205	2,975,371	86.9%	$249	$316	26.9%
Utah	15.5%	8.3%	163,811	348,665	79.2%	$245	$302	23.4%
Vermont	13.6%	6.9%	15,376	58,693	88.2%	$587	$546	-7.1%
Virginia	15.1%	8.8%	328,880	738,858	82.7%	$306	$380	24.1%
Washington	15.6%	8.4%	344,620	775,837	78.0%	$314	$351	11.9%
West Virginia	15.6%	8.4%	33,191	145,591	91.6%	$347	$468	35.1%
Wisconsin	10.4%	6.4%	215,407	506,471	86.8%	$258	$463	79.6%
Wyoming	16.4%	8.6%	29,076	66,105	85.6%	$434	$577	32.9%
National	**16.6%**	**9.5%**	**11,931,125**	**30,149,705**	**83.4%**	**$314**	**$405**	**28.9%**

Assumes all ACA provisions are implemented by 2014, even provisions effective later. Results are similar to what would be expected by 2017, but presented in 2014 dollars and counts. Average non-group PMPM includes total expected claims costs for members but excludes other important items that are needed to model premium, including admin, taxes, and subsidies. States with large high risk pools may consider transitioning these enrollees into the exchange over a longer time frame in order to mitigate cost increases.

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II. Methodology: Model and Database Overview

In the sections that follow, we provide an overview of our methodology, including discussion of our model and database used in this analysis. We then present our analysis and results for an example state (Wisconsin) for each of the eight questions outlined above.[4]

We have provided technical notes for the report throughout and in the appendices, including model results in excel files for all 50 states plus the District of Columbia that can be found on the SOA website with this report.

HBSM uses the 2002-2005 Medical Expenditure Panel Survey (MEPS) data to provide the underlying distribution of health care utilization and expenditures across individuals by age, sex, income, source of coverage, and employment status.[5] The MEPS contains a sample of households that is representative of the economic, demographic and health sector characteristics of the population. The database is re-weighted to reflect population control totals reported in the pooled 2008-2010 March Current Population Survey (CPS) data for each of the 50 states and the District of Columbia. It is also adjusted to presume 2014 health care utilization and expenditures across the categories as described below.

These weight adjustments are done with an iterative proportional-fitting model, which adjusts the data to match approximately 250 separate classifications of individuals by socioeconomic status, sources of coverage, and job characteristics in the CPS.[6] Iterative proportional fitting is a process where the sample weights for each individual in the sample are repeatedly adjusted in a stepwise fashion until the database simultaneously replicates the distribution of people across each of these variables in the state.[7] This approach is repeated for each state so that in the end, we effectively have 51 state databases that reflect the unique population characteristics of each state on the 250 separate dimensions.

This approach permits us to simultaneously replicate the distribution of individuals across a large number of variables while preserving the underlying distribution of individuals by level of health care utilization and expenditures as reported in MEPS. These data can be "fine- tuned" in the re-weighting process to reflect changes in health service utilization levels (e.g., hospitalizations). This approach implicitly assumes that the distribution of utilization and expenditures within each of the population groups controlled for in this re-weighting processes are the same as reported in the MEPS data. Finally, population counts were projected to 2014 base year using Census Bureau population projections by state, age and sex.

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4 Wisconsin was chosen as an example for this report because several of the members of the oversight committee were familiar with Wisconsin, making this state a more interesting case study for understanding why the model was producing its results than other states considered for the example. While there are a few states that more closely align with the overall national scenario, one of the key findings of this report is that the ACA's effect on enrollment and cost is expected to vary widely, making even states that align with the national scenario an atypical scenario. Further, we do not represent the national scenario because it is a roll up of many circumstances.

5 For some applications, we pool the MEPS data for 2002 through 2005 to increase sample size. This is particularly useful in analyzing expenditures for people with high levels of health spending, which typically represents only a small proportion of the database.

6 To bolster sample size for state level analyses, we have pooled the CPS data for 2008 through 2010. This is important when using the model to develop state-level analyses.

7 The process used is similar to that used by the Census Bureau to establish final family weights in the March CPS.

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We also adjust the health expenditure data reported in the MEPS database for each state to reflect changes in the characteristics of the population in 2014. These data are adjusted to reflect projections of the health spending by type of service and source of payment in the 2014 base year. These spending estimates are based upon state-level health spending data provided by CMS and detailed projections of expenditures for people in Medicare and Medicaid across various eligibility groups. Spending data for the employer market are based on average premiums published in the MEPS Insurance Component data by firm size and state. We also adjust spending for the non-group market using state-by-state premium data obtained from the National Association of Insurance Commissioners' 2010 Supplemental Health Care Exhibit Report trended to 2014.

The result is a database that is representative of the base year population in each state by economic and demographic group, which also provides extensive information on the joint distribution of health expenditures across population groups. See **Appendix A** and **Appendix B** for a description of the model, databases and key assumptions. A more detailed documentation can be found at http://www.lewin.com/publications/publication/413/.

III. Analysis & Results

To best understand the cost of the newly insured and impact on the non-group market under the ACA, we answer a set of six questions. Our analyses for each of these questions are described below and results are presented for an example state (Wisconsin). The same tables are shown on the SOA website for all states, there are no special considerations with respect to Wisconsin, except it was one of several states reviewed closely by the Project Oversight Group. To provide a range of estimates for this analysis, we also provide a set of six scenarios using various assumptions about implementing the Medicaid expansion and the availability of premium subsidies as well as results using two different participation models, a price elasticity based model and a utility function model.

Research Questions

Question 1: What is the anticipated enrollment for the currently uninsured under the ACA?

To estimate the anticipated enrollment for the currently uninsured under the ACA, we model uninsured individual's decision to enroll through the exchanges, Medicaid or newly offered employer plans. The purpose of the participation model is to estimate the shifts in insurance coverage occurring under the ACA, including the number of individuals enrolling in the state health insurance exchanges. This is a complex task requiring detailed analysis of employer and individual responses to programs and incentives created under the ACA. Our approach is to estimate the effect of the features of the ACA that affect the employer decision to either offer or discontinue Employer- Sponsored Insurance (ESI) and whether to offer coverage through the Small Business Health Options (SHOP) exchange if eligible. Once the employer coverage decisions are estimated, our population model estimates individual enrollment into the various coverage options available under ACA, including the expanded Medicaid program, the employer's plan and individual non-group coverage in the exchange, where premium subsidies are available for individuals up to 400 percent of federal poverty level (FPL).

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The population model will be used to estimate the number and characteristics of employers and individuals electing to participate in each of the various forms of public and private coverage, in particular the number and characteristics of individuals participating in the Small Business Health Options (SHOP) exchange and the individual exchange. The key characteristics of individuals contained in the model include demographic characteristics, income, employment status, health risk profile, health utilization and health spending experience.

Appendix A and Appendix B describe the key assumptions used to model each of these key decision points for transitions from current coverage to new options under the ACA.

Figure 1 shows transitions in coverage under the ACA for Wisconsin. In each of the analyses, we make the simplifying assumption that all the ACA provisions are fully implemented (2016 provisions) in 2014. The first column of the table shows the number of individuals in the state by source of coverage prior to the ACA. The remaining columns show the transitions in coverage for those individuals due to the options available under the ACA. Here, many individuals previously covered by small employers (2-50) will transition into the employer or individual exchange (31 percent). Many individuals previously enrolled in other non-group coverage will enroll through the individual exchange (42 percent) or Medicaid (10 percent), as a result of Medicaid expansion. Of those previously uninsured, 26 percent will enroll in Medicaid, 19 percent will enroll in the individual exchange, 14 percent will select employer coverage through the exchange or privately, and 40 percent will remain uninsured. In total, about 276,000 individuals, or 4.8 percent of the Wisconsin population, will remain uninsured in 2014, under a fully implemented ACA.

Figure 1: Changes in Sources of Coverage under the ACA for Wisconsin[1/]
(Assumes Medicaid Expansion)

		Transitions in Coverage under the ACA						
Baseline Coverage	**Total**	**Employer Exchange [4/]**	**Individual Exchange**	**Private Employer**	**Private Non-Group**	**Medicare/ TRICARE**	**Medicaid/ CHIP**	**Uninsured**
Employer 2-50	678,829	174,937	37,701	440,492	513	2	19,836	5,348
Employer 51-100	140,608	24,533	6,421	107,757	13	0	1,341	542
Employer 101+	2,350,507	0	55,441	2,249,878	1,039	241	34,018	9,890
High Risk Pool	24,910	473	20,834	1,659	0	0	1,945	0
Other Non-Group	215,407	5,130	92,736	16,008	62,744	0	22,298	16,490
Retiree [2/]	71,767	0	0	60,075	0	0	11,692	0
TRICARE	73,399	0	0	0	0	73,399	0	0
Medicare	710,938	0	0	0	0	710,938	0	0
Dual Eligible	183,423	0	0	0	0	183,423	0	0
Medicaid/CHIP [3/]	738,645	6,098	46,610	14,180	314	41	671,402	0
Uninsured	602,647	23,400	116,403	63,472	1,250	0	154,357	243,764
% of Currently Uninsured		3.9%	19.3%	10.5%	0.2%	0.0%	25.6%	40.4%
Total	**5,791,080**	**234,572**	**376,148**	**2,953,521**	**65,873**	**968,045**	**916,889**	**276,034**

1/Assumes that all ACA provisions are fully implemented. Population by coverage source is presented as average monthly counts in 2014.
2/ Retiree coverage is defined as people with early employer retiree coverage who are not working.

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3/ To compare Medicaid enrollment to other sources (e.g., Statehealthfacts) Medicaid, CHIP and Dual eligibles should be added together.
4/ Employer exchange enrollment is modeled assuming all qualifying firms participate in the premium tax credit program in the initial year. However, the credit is available to each employer for only 2 years and participation has been lower than expected.

We assume that some current Medicaid recipients will enroll in their employers plan if newly offered (part-timers newly eligible, for example). Also, in states that currently provide coverage to adults above 138 percent of FPL we assume these states will discontinue that coverage in 2014 when subsidies become available and move these people into the Exchanges. [8] The following table compares the results of our analysis (for the nonelderly only) to the estimates produced by the Congressional Budget Office (CBO).

U.S. Counts	CBO 2018 (in millions) [1/]		Lewin 2014 (full phase in) in millions	
Coverage Source	Prior Law Coverage	Change under ACA	Prior Law Coverage	Change under ACA
Medicaid/CHIP	31	16	46	17
Employer	160	-5	157	-2
Non-Group and Other	31	-3	22	-5
Exchange	-	23	-	21
Uninsured	58	-31	52	-31
Total	280	--	276	--

1/ March 2012 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage. Estimates for 2018 are presented which represents full implementation.

Monthly spending for each group is shown in ***Figure 1A***, below. Here, under the ACA, the largest cost increases are seen in those transitioning from large employer coverage to the individual exchange or the private non-group market, in retirees transitioning to Medicaid/CHIP, and in the uninsured transitioning to private employer or private non-group coverage. Largest decreases in costs are seen in those transitioning from small employer (2-50) coverage to the private non-group market, in those transitioning from mid-sized (51-100) employer coverage to Medicaid/CHIP, and those transitioning from Medicaid to private non-group coverage. The technical notes, provided below, explain differences in costs for people leaving employer coverage for non-group.

[8] States that currently offer coverage to adults above 138% FPL include CT, DC, IL, ME, MN, NJ, NY, RI, TN, VT and WI.

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Figure 1A: Average Morbidity (Monthly Costs) under the ACA for Wisconsin
(Assumes Medicaid Expansion)

		Transitions in Coverage under the ACA						
Baseline Coverage	**Total**	**Employer Exchange**	**Individual Exchange**	**Private Employer**	**Private Non-Group**	**Medicare/ TRICARE**	**Medicaid/ CHIP**	**Uninsured**
Employer 2-50	$476	$537	$559	$433	$151	$25	$527	$160
Employer 51-100	$573	$486	$671	$583	$617	$0	$121	$906
Employer 101+	$567	$0	$1,061	$552	$1,128	$289	$362	$301
High Risk Pool	$1,176	$1,220	$939	$1,808	$0	$0	$2,155	$0
Other Non-Group	$258	$249	$240	$165	$320	$0	$194	$159
Retiree	$187	$0	$0	$182	$0	$0	$1,730	$0
TRICARE	$650	$0	$0	$0	$0	$649	$0	$0
Medicare	$902	$0	$0	$0	$0	$902	$0	$0
Dual Eligible	$1,274	$0	$0	$0	$0	$1,279	$0	$0
Medicaid/CHIP	$393	$468	$391	$331	$41	$533	$407	$0
Uninsured	$154	$320	$317	$556	$2,054	$0	$378	$108
Total	**$542**	**$503**	**$482**	**$526**	**$363**	**$954**	**$418**	**$120**

Assumes that all ACA provisions are fully implemented. Costs include total expected health care spending PMPM in 2014 but should not be confused with premium, since important items such as administrative costs, taxes, and premium subsidies are not included.

Population Movement

The population movement under the ACA is estimated using various simulation decisions for employers and individuals in the micro-simulation database. HBSM includes a model of the individual insurance market. The model defines the non-group insurance markets to include all people who are not otherwise eligible for coverage under an employer plan, Medicare, Medicaid or TRICARE (i.e., military dependents and retirees). The model simulates premiums for individuals using the rules that prevail in each state. Premiums can be varied by age, gender and health status. This is done by compiling a "rate book" based upon the HBSM health spending data for the state reflecting how costs vary with individual characteristics.

Once the employer coverage option is simulated for employers, we simulate individual take- up of insurance given the options available. We begin by simulating eligibility and enrollment for the Medicaid program. The probability model of enrollment that we use shows a lower rate of enrollment for people with access to employer coverage. We then simulate enrollment in employer health plans for people who have access to employer insurance. Finally, we simulate the decision to take non-group coverage based upon the cost of insurance less the premium subsidy, if eligible.

We do this by using an individual insurance rating model to estimate the premium an individual would pay for a standard benefits package under current rating practices and again under the ACA reform rating rules. [9] We then estimate the premium subsidies an individual

[9] The standard benefit plan is an illustrative "silver" tiered plan covering all acute care services except adult dental

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would be eligible to receive under the ACA to determine the net cost of insurance to the individual. In addition, for people subject to the mandate, we treat the amount of the penalty for not having insurance as an increase in the cost of being uninsured which reduces the net cost of insurance to the individual.

We simulate the decision to take coverage based upon the change in the net cost of coverage to the individual under reform using a multivariate analysis of the likelihood of taking coverage given the premium and other demographic characteristics. The multivariate model shows an implicit price elasticity of -3.4, which is similar to other published estimates. The implicit price elasticity varies with the characteristics of the individual. In general, the sensitivity to price declines as age and income increases.

Similarly, we simulate discontinuations of coverage for people who have non-group coverage under current law reflecting increases in premiums due to changes in insurer rating practices. In general, younger and healthier people will see premium increases while older and less healthy people will see reductions in premiums.

Figure 2 shows the distribution of people currently (pre-ACA) uninsured in the state by age, poverty level and self-reported health status. Similar to ***Figure 1***, the remaining columns show the transitions in coverage for the uninsured due to the options available under the ACA. The last column of the table shows percentage of people remaining uninsured under the ACA.

The highest percentage of people remaining uninsured under the ACA will be for those under age 19 (60 percent) since the Medicaid expansion does not affect children, those with incomes at or above 400 percent of FPL (71 percent), and those with excellent self-reported health status (43 percent). [10] This, in part, reflects a level of adverse selection, as these uninsured individuals likely have less perceived risk of illness and thus less perceived need for insurance coverage. Affordable coverage may also be less accessible for those over 400 percent of FPL, as they do not qualify for subsidies in the exchanges.

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and our assumption for cost sharing for this tiered plan. Assumes covered services to be the same across all states.

[10] The MEPS survey asks respondents to rate their own health status and the health status of each family member as excellent, very good, good, fair or poor. This is based on the respondent's perception of their health and not based on the prevalence actual medical conditions.

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Figure 2: Changes in Sources of Coverage under the ACA for Currently Uninsured by Age, Income and Self-reported Health for Wisconsin (assumes Medicaid expansion)

		Transitions in Coverage under the ACA						
	Total at Baseline	Employer Exchange	Individual Exchange	Private Employer	Private Non-Group	Medicaid/ CHIP	Remain Uninsured	% Remain Uninsured
Age								
Under 19	76,268	2,392	16,882	4,056	343	7,174	45,420	59.6%
19-24	128,940	5,502	17,423	22,722	15	48,567	34,711	26.9%
25-34	139,767	5,056	24,789	13,032	276	34,173	62,442	44.7%
35-44	104,605	4,712	20,479	8,520	176	23,925	46,792	44.7%
45-54	84,871	2,715	20,190	9,294	266	18,591	33,814	39.8%
55 & over	68,197	3,022	16,640	5,848	174	21,927	20,585	30.2%
Poverty Level								
Below 138% FPL	261,397	8,623	10,871	22,374	415	147,411	71,703	27.4%
138%-199% FPL	81,204	2,490	36,635	8,958	99	5,256	27,765	34.2%
200%-299% FPL	105,067	5,758	41,227	11,932	402	1,131	44,617	42.5%
300%-399% FPL	67,041	3,776	18,771	6,896	249	369	36,980	55.2%
400% FPL and above	87,937	2,753	8,899	13,311	85	190	62,698	71.3%
Self-Reported Health Status								
Excellent	463,762	16,750	88,738	51,777	816	106,536	199,144	42.9%
Good	108,637	5,416	22,813	9,772	206	33,303	37,128	34.2%
Fair	24,637	1,219	3,764	1,678	205	11,535	6,237	25.3%
Poor	5,611	15	1,089	246	23	2,984	1,255	22.4%
Total	**602,647**	**23,400**	**116,403**	**63,472**	**1,250**	**154,357**	**243,764**	**40.4%**

Assumes that all ACA provisions are fully implemented, population counts in 2014

Question 2: What is the newly insured's relative morbidity compared to the currently insured and what could reasonably be expected for relative costs? What will be the newly insured's pent up demand and for which types of services?

To estimate the newly insured's relative morbidity and costs compared to the currently insured, we use the MEPS data in the HBSM model, which report that health services utilization for uninsured individuals are substantially less than that for insured individuals. Physicians' visits per 1,000 individuals are about 1,366 for the uninsured compared with 3,282 for insured individuals under age 65. Also, hospital stays for the insured are more than double that of the uninsured. Part of the difference in utilization rates is due to the fact that the uninsured are on average younger than insured individuals. Consequently, we adjust for this when estimating how utilization would change for this population as they become insured.

We assume that uninsured individuals who become covered under the ACA would use health care services at the same rate reported by currently insured individuals with similar age, sex, income and health status characteristics. This assumption encompasses two important effects. First, the increase in access to primary care for this population would result in savings due to a

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reduction in preventable emergency room visits and hospitalizations. Second, there would be a general increase in the use of elective services such as primary care, corrective orthopedic surgery, advanced diagnostic tests, and other care that the uninsured either forego or delay.

Using this methodology, we estimate that health spending among the currently uninsured population would increase as they become insured. That is, savings from improved primary care would be more than offset by increased use of other care, including elective services. Overall, this method results in an estimated increase in utilization of about 100 percent in spending if the uninsured were to become insured.

Figure 3 shows the number of people newly covered under the ACA by age, poverty level and self-reported health status. The table also shows the average monthly costs before and after becoming insured as well as the percent increase in health care spending. Costs in this report include total personal acute care health spending for covered and non-covered services. In total, this newly insured group will cost 112 percent more than they cost prior to gaining coverage.

Figure 3: Number and Cost of Newly Insured by Age, Income and Self-reported Health Status in Wisconsin (assumes Medicaid expansion)

	Number Newly Insured Under ACA	Average Monthly Cost Pre-ACA	Average Monthly Cost Post-ACA	Percent Change in Average Costs
Age				
Under 19	30,848	$101	$183	80.6%
19-24	94,229	$100	$199	97.8%
25-34	77,325	$146	$236	61.8%
35-44	57,813	$226	$400	76.5%
45-54	51,056	$221	$786	254.9%
55 & over	47,612	$380	$730	92.1%
Poverty Level				
Below 138% FPL	189,694	$209	$488	133.2%
138%-199% FPL	53,439	$144	$243	68.7%
200%-299% FPL	60,450	$156	$294	87.9%
300%-399% FPL	30,061	$172	$317	84.7%
400% FPL and above	25,239	$174	$310	78.4%
Self-Reported Health Status				
Excellent	264,617	$112	$278	148.9%
Good	71,509	$299	$575	92.0%
Fair	18,400	$463	$828	78.9%
Poor	4,357	$1,588	$2,475	55.8%
Total	**358,883**	**$185**	**$392**	**111.9%**

Assumes that all ACA provisions are fully implemented. Costs include total expected health care spending PMPM in 2014 but should not be confused with premium, since important items such as administrative costs, taxes, and premium subsidies are not included.

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Pent Up Demand for Services

This analysis does not include an increase in utilization due to pent up demand. Our modeling assumes an ultimate enrollment for all provisions of the ACA in the initial year of the program and does not address enrollment ramp-up issues or utilization for unmet needs of the newly insured.

The research on "pent-up" demand for health care services as individuals become newly insured has shown mixed results. A study of near elderly uninsured who are approaching Medicare eligibility found that pent-up demand exists for physician care, but not for hospital inpatient care. The study estimated that the individuals who were uninsured prior to Medicare enrollment have 30 percent more physician visits during the two years after Medicare enrollment than their previously insured counterparts.[11] Another study of the near-elderly indicate that the increased utilization experienced after age 65 by those who were uninsured prior to Medicare lead to an elevated hazard of diagnosis (relative to the insured) for virtually every chronic condition considered, for both men and women and the magnitudes of these effects are clinically meaningful.[12] A study of children newly enrolled in Medicaid found no evidence of pent-up demand for medical care among newly insured children, when they were compared to children who had been continuously insured.[13] Another study examined the effects of the Oregon Medicaid lottery after approximately one year of insurance coverage. The study presented estimates of the impact of insurance coverage, using the lottery as an instrument for insurance coverage, found no evidence of a larger initial utilization effect, suggesting that such "pent up" demand effects may not in fact be present. However, the longer run impact of health insurance on health care utilization could differ from the one-year effects. [14]

Since the possibility of pent-up demand is an important risk, especially in 2014 and 2015, the information presented in any of the Tables, which do not factor in pent-up demand, can be adjusted by the reader to reflect an assumption for pent-up demand.

Question 3: What will be the general impact of the newly insured on the overall post-reform health care industry and insurance market, in terms of supply and demand for health care services?

To measure the general impact of the newly insured on the overall post-reform health care industry and insurance market, we use the HBSM micro-simulation model to measure the impact that increased utilization of health services for newly insured has on overall health spending. As described above, we assume that uninsured individuals who become newly covered would use health care services at the same rate reported by currently insured

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11 Li-Wu Chen, Wanqing Zhang, Jane Meza, Roslyn Fraser, MA, "Pent-up Demand: Health Care Use of the Uninsured Near Elderly," Economic Research Initiative on the Uninsured Working Paper Series, July 2004

12 Schimmel, Jody. "Pent-Up Demand and the Discovery of New Health Conditions after Medicare Enrollment" Paper presented at the annual meeting of the Economics of Population Health: Inaugural Conference of the American Society of Health Economists, TBA, Madison, WI, USA, June 04, 2006

13 K. Goldsteen, R.L. Goldsteen, "Demand For Medical Services Among Previously Uninsured Children: The Roles of Race and Rurality," South Carolina Rural Health Research Center, Arnold School of Public Health, University of South Carolina, October 2002

14 Amy Finkelstein et. al., "The Oregon Health Insurance Experiment: Evidence from the First Year ," No. w17190, National Bureau of Economic Research, 2011

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individuals with similar characteristics. [15] The information provided below can be used to estimate increased health services demand as a result of the newly insured in a state. Although the table gives increases for the entire state and the relative impacts across the state can vary depending on uninsured rates and provider supply.

Figure 4 shows the total statewide spending by type of service for all insured (Column 2) and uninsured (Column 3) state residents, before accounting for the effects of the ACA. The fourth column shows the estimated increase in spending by the newly insured under the ACA by type of service. The last column presents the percent increase in system-wide spending due to the newly insured as a percent of total state-wide health spending. In this example, the increase in utilization of services by newly insured people will result in a 2.0 percent total increase in state-wide health care spending in Wisconsin under the ACA.

Figure 4: Change in Spending as a Percent of Total Spending by Type of Service in Wisconsin (millions) (assumes Medicaid expansion)

Type of Service	Spending Under Current Law by Insured Population	Spending Under Current Law by Uninsured Population	Increase in Spending Under ACA by Newly Insured	Percent Change in System-Wide Spending
Hospital Inpatient	$12,230.6	$372.3	$352.3	2.8%
Physician	$12,603.9	$386.2	$276.4	2.1%
Dental	$2,464.9	$88.0	$5.1	0.2%
Other Professional	$1,499.7	$50.9	$28.3	1.8%
Prescription Drugs	$5,492.8	$199.6	$78.8	1.4%
Medical Equipment	$489.8	$25.3	$15.5	3.0%
Hospital Outpatient	$6,852.4	$252.7	$107.6	1.5%
Total	**$41,634.1**	**$1,375.0**	**$864.0**	**2.0%**
Population	5,188,433	602,647	358,883	
Spending Per Person	$8,003.7	$2,281.6	$2,432.6	

1/Assumes that all ACA provisions are fully implemented. Spending by type of service in the MEPS data is adjusted to match CMS state health expenditures by type of service trended to 2014.

Question 4: How will premium rates in the non-group market be impacted by the new population mix? How will health care costs be impacted by the presence of the high risk pools under the ACA and how are current costs impacted by current state high risk pools?

For this report, we focused only on the changes in allowable costs. Actual premiums will vary for each insurer based on many factors which are beyond the scope of this report, since each insurer will have different circumstances and strategies with regard to competition. Besides traditional pricing inputs, 2014 will also bring to individual exchanges risk mitigation programs: reinsurance, risk corridors and risk adjustment. Reinsurance and risk corridors are

[15] Our assumption varies from the Congressional Budget Office (CBO) assumption that newly insured individuals will use between 75 and 95 percent as much as people who are currently insured. “Key Issues in Analyzing Major Health Insurance Proposals”, December 18, 2008.

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temporary programs for the first three years and risk adjustment is designed to be market neutral. Therefore, these considerations are not addressed here, even though they will be a major source of analysis and conjecture as premiums are developed for 2014 through 2016.

In order to model the impact of the high risk pools, we first project enrollment to the end of 2013 and allowed costs for the state high risk pool, if present, and then the new Federal Pre-Condition Insurance Plan (PCIP). Those figures are used to assign high risk pool coverage to a subset of the non-group market.

An important finding is that new individual coverage for those currently with group coverage will have a significant impact on costs in the individual Exchange. Although the number of employers dropping coverage is not high, their impact in the non-group market can be significant (see technical notes below).

Figure 5 shows the impact of the ACA on the non-group market. This analysis shows the current enrollment and costs for the fully insured individual market and the high-risk pools. The high risk pools include both the state high-risk pool and the temporary federal high-risk pools under the ACA. This table presents the dynamics that we estimate will occur under the ACA. The first two lines show the number of individuals in the high-risk pools and the individual market and their average monthly total health care spending.

Line 3 shows the number of individuals and average costs for individuals currently covered in the high-risk pool or the individual market that leave due to the availability of other coverage options under the ACA. Lines 4 through 6 show the number of people who remain in the individual market and their average monthly spending. Lines 7 through 11 show the impact due to people entering the non-group market under the ACA from employers that discontinue coverage, Medicaid adults above 138 percent of FPL that we assume will get moved to the Exchanges and previously uninsured.

The last line shows the number of individuals and the average monthly spending per person in the Wisconsin non-group market under the ACA—about 442,020 and $464 per month, respectively.

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Figure 5: Change in Average Costs in the Non-Group Market under ACA in Wisconsin
(assumes Medicaid expansion)

	Membership	Average Cost Per Month
1. Current High Risk	**24,910**	**$1,176**
2. Current Other Non-Group	**215,407**	**$258**
3. Leave Non-Group	64,003	$291
Retain Non-Group		
4. In Exchange High Risk	20,834	$939
5. In Exchange Other	92,736	$240
6. Outside Exchange	62,744	$320
Leave Other Coverage to take Non-Group		
7. Employer 2-50	38,214	$554
8. Employer 51-100	6,434	$671
9. Employer 101+	56,480	$1,062
10. Medicaid/CHIP	46,925	$389
11. Uninsured	117,654	$336
Individuals with Non-Group under ACA	**442,020**	**$464**

Assumes that all ACA provisions are fully implemented. Costs include total expected health care spending PMPM in 2014 but should not be confused with premium, since important items such as administrative costs, taxes, and risk mitigation programs are not included.

Figure 6 shows the distribution of, and average costs for, individuals currently in the non-group market by age, poverty level and self-reported health status, along with their average monthly spending. For this table, we assume that the non-group market consists of the fully insured individual market and the high-risk pools. The table compares those figures with the distribution and average monthly spending for individuals who we estimate will take non-group coverage under the ACA. Here, in the non-group market, we see the greatest increase in average monthly costs for individuals ages 55 and over (a 68 percent increase), those with incomes at or above 400 percent of FPL (an 83 percent increase), and those with a self-reported health status of “fair” or “poor.” In total, the change in average monthly costs for non-group coverage increases by 32 percent under the ACA. The average increase per person is 29 percent but varies by age.

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Figure 6: Distribution of Non-Group Coverage Pre- and Post-ACA by age, income and health status in Wisconsin (assumes Medicaid expansion)[1/]

	Non-Group under Current Law			Non-Group under ACA			
	Number	Percent Distribution	Average Monthly Cost	Number	Percent Distribution	Average Monthly Cost	Change in Avg Mo Cost
Age							
Under 19	32,480	13.5%	$171	71,054	16.1%	$189	10.6%
19-24	34,787	14.5%	$190	53,464	12.1%	$186	-2.4%
25-34	39,606	16.5%	$255	81,396	18.4%	$322	26.2%
35-44	31,570	13.1%	$310	76,544	17.3%	$380	22.5%
45-54	42,976	17.9%	$497	79,242	17.9%	$688	38.2%
55 & Over	58,898	24.5%	$533	80,319	18.2%	$896	68.2%
				Average Increase per Person			29.4%
Family Income in Month as a Percent of the Federal Poverty Level (FPL)							
Below 138% FPL	64,587	26.9%	$405	59,563	13.5%	$393	-2.9%
138%-200% FPL	18,798	7.8%	$419	92,955	21.0%	$340	-18.9%
200%-300% FPL	37,122	15.4%	$334	105,406	23.8%	$498	49.1%
300%-400% FPL	37,950	15.8%	$246	70,506	16.0%	$337	37.0%
400% FPL and Over	81,860	34.1%	$355	113,590	25.7%	$649	83.1%
Self-reported Health Status							
Excellent	206,978	86.1%	$281	355,079	80.3%	$310	10.2%
Good	27,069	11.3%	$686	71,065	16.1%	$668	-2.7%
Fair	5,500	2.3%	$906	12,777	2.9%	$2,556	182.0%
Poor	770	0.3%	$3,992	3,099	0.7%	$4,818	20.7%
Total	**240,317**	**100%**	**$353**	**442,020**	**100%**	**$464**	**31.5%**

1/ Assumes that all ACA provisions are fully implemented. Costs include total expected health care spending PMPM in 2014 but should not be confused with premium, since important items such as administrative costs, taxes, and risk mitigation programs are not included.

Figure 6A shows the same metrics as ***Figure 6***; however this figure excludes the high-risk pool members from the current non-group population. Excluding the high-risk pool results in a significantly greater change in average monthly costs for non-group coverage as compared to ***Figure 6*** (80 percent versus 30 percent). The average increase per person is 68 percent versus 29 percent, and the increase varies significantly by age.

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Figure 6A: Distribution of Non-Group Coverage (Excluding High-Risk Pool) Pre- and Post-ACA by age, income and health status in Wisconsin (assumes Medicaid expansion)

	Non-Group under Current Law			Non-Group under ACA			
	Number	Percent Distribution	Average Monthly Cost	Number	Percent Distribution	Average Monthly Cost	Change in Avg Mo Cost
Age							
Under 19	31,952	14.8%	$167	71,054	16.1%	$189	13.0%
19-24	34,197	15.9%	$172	53,464	12.1%	$186	8.3%
25-34	36,993	17.2%	$219	81,396	18.4%	$322	47.1%
35-44	28,983	13.5%	$227	76,544	17.3%	$380	67.5%
45-54	37,487	17.4%	$322	79,242	17.9%	$688	113.8%
55 & Over	45,795	21.3%	$384	80,319	18.2%	$896	133.2%
				Average Increase per Person			68.1%
Family Income in Month as a Percent of the Federal Poverty Level (FPL)							
Below 138% FPL	58,113	27.0%	$239	59,563	13.5%	$393	64.5%
138%-200% FPL	17,201	8.0%	$322	92,955	21.0%	$340	5.8%
200%-300% FPL	33,093	15.4%	$220	105,406	23.8%	$498	126.4%
300%-400% FPL	33,467	15.5%	$207	70,506	16.0%	$337	62.7%
400% FPL and Over	73,532	34.1%	$298	113,590	25.7%	$649	118.1%
Self-reported Health Status							
Excellent	192,143	89.2%	$227	355,079	80.3%	$310	36.2%
Good	19,863	9.2%	$500	71,065	16.1%	$668	33.7%
Fair	3,222	1.5%	$582	12,777	2.9%	$2,556	339.3%
Poor	179	0.1%	$149	3,099	0.7%	$4,818	3128.0%
Total	**215,407**	**100%**	**$258**	**442,020**	**100%**	**$464**	**80.0%**

Assumes that all ACA provisions are fully implemented. Costs include total expected health care spending PMPM in 2014 but should not be confused with premium, since important items such as administrative costs, taxes, and risk mitigation programs are not included.

Question 5: What will be the relative health status and cost for people who remain uninsured under the ACA and how will this differ by state?

Figure 7 shows the distribution of uninsured individuals under current law in the state by age, poverty level and self-reported health status along with their average monthly spending. The table compares those estimates with the distribution and average monthly spending for individuals who we estimate will remain uninsured under the ACA.

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Figure 7: Distribution of Uninsured Pre- and Post-ACA by Age, Income and Health Status in Wisconsin (assumes Medicaid expansion)[1/]

	Uninsured under Current Law			Remain Uninsured under ACA			
	Number	Percent Distribution	Average Monthly Cost	Number	Percent Distribution	Average Monthly Cost	Change in Avg Mo Cost
Age							
Under 19	76,268	12.7%	$80	45,420	18.6%	$66	-17.8%
19-24	128,940	21.4%	$101	34,711	14.2%	$104	2.7%
25-34	139,767	23.2%	$118	62,442	25.6%	$82	-30.3%
35-44	104,605	17.4%	$174	46,792	19.2%	$108	-37.8%
45-54	84,871	14.1%	$183	33,814	13.9%	$125	-31.8%
55 & Over	68,197	11.3%	$342	20,585	8.4%	$255	-25.4%
				Average Increase per Person			-24.5%
Family Income in Month as a Percent of the Federal Poverty Level (FPL)							
Below 138% FPL	261,397	43.4%	$183	71,703	29.4%	$114	-37.5%
138%-200% FPL	81,204	13.5%	$118	27,765	11.4%	$69	-41.8%
200%-300% FPL	105,067	17.4%	$132	44,617	18.3%	$99	-24.9%
300%-400% FPL	67,041	11.1%	$129	36,980	15.2%	$94	-27.3%
400% FPL and Over	87,937	14.6%	$144	62,698	25.7%	$132	-8.6%
Self-reported Health Status							
Excellent	463,762	77.0%	$103	199,144	81.7%	$91	-11.4%
Good	108,637	18.0%	$253	37,128	15.2%	$164	-35.2%
Fair	24,637	4.1%	$413	6,237	2.6%	$268	-35.1%
Poor	5,611	0.9%	$1,295	1,255	0.5%	$279	-78.5%
Total	**602,647**	**100%**	**$154**	**243,764**	**100%**	**$108**	**-29.9%**

1/ Assumes that all ACA provisions are fully implemented. Costs include total expected health care spending PMPM in 2014 and should not be confused with premium.

Here, across most all age groups, income levels, and health statuses, we see a decrease in average monthly costs for the uninsured under the ACA, with an average decrease of 30 percent across all groups. This analysis indicates that individuals remaining uninsured under the ACA will be younger, healthier and have higher incomes than the current uninsured population. Those remaining uninsured include undocumented individuals who are not eligible for subsidies, low income families who would not be impacted by the penalty and people with an unaffordable offer of coverage (more than 8 percent of income) who also would not be affected by the penalty.

Question 6: Assuming the state expands Medicaid under the ACA, what is the impact on Medicaid enrollment and costs?

Figure 8 shows the impact of the ACA on the Wisconsin Medicaid program, assuming the state had expanded Medicaid. The first line shows the enrollment and average Medicaid per member per month costs for individuals currently in the Medicaid program (excluding dual

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Medicare/Medicaid enrollees). The table compares those figures with the distribution and average monthly Medicaid spending for people who we estimate will be covered by Medicaid under the ACA. The total net change in Medicaid enrollment will be 178,244 more than pre-ACA projected enrollment; newly eligible will cost more, on average, than currently eligible.

Figure 8: Change in Medicaid Enrollment and Costs under the ACA with Medicaid Expansion in Wisconsin[1/]

	Enrollment	Medicaid Costs PMPM
Current Program	738,645	$321
Leave Medicaid for other Coverage		
Children	(10,514)	$147
Parents/Other	(56,729)	$286
Currently Eligible		
Children	6,948	$279
Parents/Other	11,398	$405
Newly Eligible		
Parents/Other	5,928	$336
Non-Custodial Adults	221,213	$410
All Newly Eligible	227,142	$408
Total Net Change	**178,244**	

1/ Assumes that all ACA provisions are fully implemented. Costs include Medicaid paid amounts PMPM presented in 2014 dollars.

Figure 9 shows the distribution of individuals currently in the Medicaid program (excluding dual Medicare/Medicaid enrollees) by age, poverty level and self-reported health status along with their average monthly total spending. The table compares those figures with the distribution and average monthly spending for individuals who we estimate will be covered by Medicaid under the ACA, assuming state participation in the Medicaid expansion. Here, those ages 19 to 24 and 55 and over will experience the most significant percent increases in the number of individuals covered by Medicaid under the ACA with expansion, compared to current law. Those below 138 percent of FPL will experience a notable percent increase in the absolute number of individuals covered by Medicaid, while families with incomes of 138 percent of FPL and above will experience percent decreases in the number of individuals covered by Medicaid as we assume that adults above 138 percent FPL will be moved to the Exchange. Across all age, income, and health status groups, with Medicaid expansion, there will be a 24 percent increase in the number of individuals covered by Medicaid under the ACA, compared to current law projections.

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Figure 9: Distribution of Medicaid Enrollees Pre- and Post-ACA by Age, Income and Health Status in Wisconsin (assumes Medicaid expansion)[1/]

	Covered by Medicaid under Current Law			Covered by Medicaid under ACA			Change in Covered
	Number	Percent Distribution	Average Monthly Cost	Number	Percent Distribution	Average Monthly Cost	Number
Age							
Under 19	438,090	59.3%	$184	435,615	47.5%	$189	-0.6%
19-24	61,895	8.4%	$690	142,575	15.5%	$405	130.4%
25-34	82,473	11.2%	$726	106,634	11.6%	$613	29.3%
35-44	77,118	10.4%	$472	88,701	9.7%	$503	15.0%
45-54	46,034	6.2%	$832	64,810	7.1%	$783	40.8%
55 & Over	33,034	4.5%	$976	78,553	8.6%	$1,047	137.8%
Family Income in Month as a Percent of the Federal Poverty Level (FPL)							
Below 138% FPL	490,595	66.4%	$386	717,526	78.3%	$416	46.3%
138%-200% FPL	119,267	16.1%	$285	91,573	10.0%	$262	-23.2%
200%-300% FPL	81,893	11.1%	$590	67,869	7.4%	$637	-17.1%
300%-400% FPL	22,903	3.1%	$345	19,016	2.1%	$389	-17.0%
400% FPL and Over	23,987	3.2%	$445	20,905	2.3%	$481	-12.8%
Self-reported Health Status							
Excellent	569,235	77.1%	$228	700,263	76.4%	$238	23.0%
Good	123,176	16.7%	$591	153,354	16.7%	$649	24.5%
Fair	37,340	5.1%	$1,284	51,173	5.6%	$1,258	37.0%
Poor	8,894	1.2%	$4,443	12,099	1.3%	$4,349	36.0%
Total	**738,645**	**100%**	**$393**	**916,889**	**100%**	**$418**	**24.1%**

1/ Assumes that all ACA provisions are fully implemented. Costs include total expected health care spending PMPM in 2014.

Alternate Scenarios & Sensitivity Testing

The included spreadsheets present our state-level analysis of the cost of the newly-insured under the ACA. For each state we generated the following three scenarios using our price elasticity based model:

1. The Lewin Group Baseline ACA Simulation with Medicaid Expansion and Exchange Subsidies between 138-400% FPL;
2. Simulation of ACA without Medicaid Expansion but Exchange Subsidies between 100-400% FPL; and
3. Simulation of the ACA without the availability of premium subsidies in the Exchanges, but includes the Medicaid Expansion;

Using a utility model, which is described in Appendix A (page A-16), we generated three additional scenarios:

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1. Baseline Utility Simulation with Medicaid Expansion and Exchange Subsidies between 138-400% FPL – using a utility model ;
2. Simulation with Medicaid Expansion and Exchange Subsidies between 138-400% FPL – using a utility model with one-third less risk aversion; and
3. Simulation with Medicaid Expansion and Exchange Subsidies between 138-400% FPL – using a utility model with two-thirds less risk aversion.

As described in ***Appendix A***, our approach is to adapt an existing model of consumer aversion to risk called the "utility" function, which has been widely used to estimate coverage under health reform. The model assigns a utility "score" to being insured equal to an individual's expected health spending less the premium, the consumer's valuation of protection from unexpected health care costs, and the value of health services consumed. For each individual, a utility score is computed separately for each of the benefits packages offered in the exchanges. From the lowest actuarial value of coverage to the highest, these will be "catastrophic," followed by bronze, silver, gold, and platinum.

We also compute a utility score for being uninsured that included an individual's average expected out-of-pocket health spending if uninsured less other costs of being uninsured, including the penalty and an implied valuation of the cost of the risk the individual faced when uninsured. We adjust health care costs for individuals to match spending levels reported by uninsured people with similar characteristics, so the costs reflect the lost utility of reduced access to health care.

People are assumed to take coverage if the utility score for any of the five benefits packages exceeds the utility score for being uninsured. Others are assumed to go without insurance. As discussed in the Appendix, the model allows for the possibility that individuals respond to a premium increase by moving to a less comprehensive health plan rather than dropping coverage.

The utility function uses the statistical variance in expected spending to represent the risk an individual faces by going without insurance. The model estimates the cost of this risk to the individual based on estimates of consumer risk aversion drawn from the literature (based on the Arrow-Pratt risk aversion theory). This could be thought of as the amount that someone is willing to pay to be protected against this risk.

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IV. Limitations and Caveats

The results of our analysis are projections, not predictions, and they are dependent upon the set of assumptions used. The results are likely to vary under a different set of assumptions. Future experience will not exactly conform to these projected results. We have conducted sensitivity testing of our results to changes in assumptions. However, given that we are modeling a complex system, changes in some assumptions can produce significant changes in results, due to the interrelationships of factors influencing the results.

We have relied on various sources for data and information upon which the underlying assumptions have been developed. In some cases, there has not been adequate experience data upon which to develop assumptions, and we have had to rely on judgment.

The analyses are based upon our understanding and interpretation of the ACA and its related regulations. Regulations provided after October, 2012 have not been modeled, so a review of Appendices A and B is recommended so the reader can confirm any subsequent changes against the model used for the results in this report. States will be allowed some flexibility in varying certain aspects of the ACA, which may impact results differently than what has been presented. Users of this report will need to make some assumptions as to how developments in each state might affect how actual results will play out.

We suggest readers carefully consider possible variations in outcomes and the actions of competitors and regulators when using this report. We suggest that actual per member per month figures generally should not be used, but instead focus on the change in figures between different risk classes. Readers will need to make important assumptions regarding possible pent-up demand in 2014 and 2015 and initial enrollment forecasts for the first two to three years will also have to be assumed and may be subject to wide variation based on assumptions for each state. How states with current high risk pools address transition to the post-ACA market will also have an important impact on results in the initial years, and adjustments should be made to report figures since the report figures assume an “ultimate” impact (generally after approximately three years).

It is advised that readers not to take any action solely with reliance on this report. Any of the results presented could prove to be different for any one state or health plan.

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V. Technical Notes

The technical notes below provide additional insights into some of the analyses results discussed above.

Leaving Employer Coverage for Non-Group Coverage

We model individuals moving from employer coverage to non-group coverage under the ACA. ***Figure 10*** shows the impact of the ACA on the non-group market in Wisconsin. Lines 7 through 9 of the table show the number of individuals and average cost for those entering the non-group market under the ACA that previously had employer coverage. The average cost for this group is substantially higher than average cost for other groups and is one of the primary reasons our simulations show a large increase in average costs in the non-group market from current law to the ACA.

Figure 10: Change in Average Costs in the Non-Group Market under ACA in Wisconsin

	Membership	Average Cost Per Month
1. Current High Risk	**24,910**	**$1,176**
2. Current Other Non-Group	**215,407**	**$258**
3. Leave Non-Group	64,003	$291
Retain Non-Group		
4. In Exchange High Risk	20,834	$939
5. In Exchange Other	92,736	$240
6. Outside Exchange	62,744	$320
Leave Other Coverage to take Non-Group		
7. Employer 2-9	38,214	$554
8. Employer 51-100	6,434	$671
9. Employer 101+	56,480	$1,062
10. Medicaid/CHIP	46,925	$389
11. Uninsured	117,654	$336
Individuals with Non-Group under ACA	**442,020**	**$464**

1/ Assumes that all ACA provisions are fully implemented. Costs include total expected health care spending PMPM in 2014 but should not be confused with premium, since important items such as administrative costs, taxes, and risk mitigation programs are not included.

Our analysis of average costs for all workers and dependents in Wisconsin shows that costs are substantially higher than for people purchasing non-group coverage under current law. The average monthly cost for people in the non-group market was $258 (excluding the high risk pool enrollees) compared to $548 for people with employer coverage.

Figure 11 shows the number of members and average monthly cost by size of group pre-ACA. Even if people with average risk in the employer group market moved to non-group they would tend to increase the average cost in the non-group market.

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Figure 11: Average Costs in the Employer Market pre-ACA in Wisconsin

Group Size	Members	Avg Cost
2-9	281,346	$491
10-50	397,483	$466
51-100	127,836	$593
101-499	473,333	$551
500-999	219,230	$532
1000-4999	299,043	$501
5000+	756,235	$569
Government	615,440	$615
Total	**3,169,944**	**$548**

1/ Assumes that all ACA provisions are fully implemented. Costs include total expected health care spending PMPM in 2014 but should not be confused with premium, since important items such as administrative costs, taxes, and risk mitigation programs are not included.

Some employers who now offer insurance will decide to discontinue that coverage under the ACA. This will occur among employers seeing an increase in premiums under the Act. We also expect some insuring employers to discontinue coverage in cases where their workers can obtain subsidized coverage through the exchange at a lower cost. These employer decisions are modeled in two steps:

- Employers dropping coverage due to increase in the net cost of coverage; and
- Employers dropping coverage in response to subsidies for individual coverage.

Employers Dropping Coverage due to Increase in the Net Cost of Coverage
In this step we assess the impact of changes in the cost of insurance to the employer on the number of employers offering coverage. Employer health insurance premiums will be affected by changes in rating practices under the Act. In general, small fully-insured employers with younger and healthier workforces will see premiums increase while employers with older and less healthy individuals will see premiums reduced. In addition, the small employer tax credit will reduce premium costs for some firms.

We use HBSM to estimate the change in net premium costs for employers under the Act. We also estimate the penalty for not offering coverage, which we treat as an increase in the cost of not offering coverage, which has the effect of reducing the net cost of obtaining insurance.

We model the decision to offer coverage using a multivariate model of how changes in premiums affect the likelihood of offering coverage. The implicit price elasticity varies from -0.87 for small firms to less than -0.20 for larger firms. This means that a one percent reduction in premiums results in a 0.87 percent increase in the number of small firms offering coverage.

Employers Dropping Coverage in Response to Subsidies for Individual Coverage
Some employers may discontinue coverage under health reform because their workers become eligible for free or subsidized coverage in the exchange. Because these subsidies are available

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only to people without access to employer coverage, the employer must discontinue its plan for the workers to get these subsidies.

We model this by:

- Estimating the number of insuring employers where workers can obtain coverage at a lower cost in the exchange (reflecting any change in premium resulting from community rating); and
- Estimating the percentage of these firms that discontinue coverage.

We model the employer decision to discontinue coverage based upon a multivariate model of how changes in the price of alternative health coverage affect the likelihood of switching to the alternative source of coverage. The plan switching elasticity is -2.54, which means that a one percent lower cost results in 2.54 percent of employers discontinuing coverage so workers can obtain subsidize coverage in the exchange.

We model the employer cost as the total premium cost (employee and employer share) less small employer tax credit if eligible less tax benefit of employer coverage. We model the cost for employees in the non-group market as the non-group premium in the Exchange less subsidies plus the cost of the employer penalty, which is assumed to be passed on to workers as lower wages. The results of our simulations show that employers with higher cost members are more likely to discontinue coverage, which would allow their workers to obtain coverage in the Exchanges at adjusted community rates and with the aid of subsidies if they are eligible.

Figure 12 shows that employees and dependents that leave employer coverage due to employers discontinuing coverage and employees leaving employer coverage on their own due to the Medicaid expansion are about 30 percent more costly than the group average member ($712 compared to $548).

Figure 12: Average Costs for Members that Leave Employer Coverage Relative to the Average for all with Employer Coverage in Wisconsin

Employer Pre-ACA			All Who Leave Employer under ACA		
Group Size	Members	Avg Cost	Group Size	Members	Avg Cost
2-9	281,346	$491	2-9	27,363	$747
10-50	397,483	$466	10-50	36,035	$489
51-100	127,836	$593	51-100	8,318	$621
101-499	473,333	$551	101-499	29,996	$631
500-999	219,230	$532	500-999	16,694	$781
1000-4999	299,043	$501	1000-4999	18,374	$536
5000+	756,235	$569	5000+	11,312	$587
Government	615,440	$615	Government	24,012	$1,282
Total	**3,169,944**	**$548**	**Total**	**172,103**	**$712**

1/ Assumes that all ACA provisions are fully implemented. Costs include total expected health care spending PMPM in 2014 but should not be confused with premium, since important items such as administrative costs, taxes, and risk mitigation programs are not included.

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Figure 13 shows the number of workers and dependents that we simulate to leave employer coverage and the programs that they would enroll into. Primarily, those below 138% of FPL will enroll in the Medicaid expansion. The average costs for this group is low relative to the average cost of all members that leave employer coverage since most are low-income, young adults. For the remainder of those that leave employer coverage, we perform a second simulation to determine who decides to purchase non-group coverage. For each individual/family, we estimate the cost of insurance under prior law and again under the ACA. These costs reflect:

- Prior law premium includes the amount that the employee paid for employer coverage; and
- Premiums under the ACA include the cost of insurance under community rating less premium subsidies in the exchange.

We estimate the likelihood of taking the coverage based upon the difference in premium before and after the ACA using a premium elasticity averaging about -3.4. This means that on average a one percent reduction in premium corresponds to a 3.4 percent increase in the number of people taking coverage.

The effect of the mandate is simulated on the basis of the penalty the individual/family would pay under the act if they remain uninsured. We treat the penalty as an increase in the cost of remaining uninsured, which has the effect of reducing the net new cost of taking coverage under the act.

The second two blocks of ***Figure 13*** shows that higher cost workers and dependents that lost employer coverage are more likely to select into non-group and those that are lower cost will opt to go uninsured due to the adjusted community rated premiums in the non-group market. Thus, our simulations show that this “double selection” effect results in relative high cost employees and dependents entering in the non-group market under the ACA.

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Figure 13: Average Costs for Members that Leave Employer Coverage and How They Sort Into Programs under the ACA in Wisconsin

Move from Employer to Medicaid			Move from Employer to Non-Group			Move from Employer to Uninsured		
Group Size	Members	Avg Cost	Group Size	Members	Avg Cost	Group Size	Members	Avg Cost
2-9	12,220	$1,028	2-9	14,345	$542	2-9	798	$120
10-50	7,616	$360	10-50	23,870	$591	10-50	4,549	$167
51-100	1,341	$144	51-100	6,434	$696	51-100	542	$906
101-499	8,209	$346	101-499	17,724	$864	101-499	4,064	$192
500-999	3,448	$187	500-999	10,535	$1,030	500-999	2,711	$571
1000-4999	4,537	$608	1000-4999	12,809	$536	1000-4999	1,027	$224
5000+	8,981	$626	5000+	2,219	$446	5000+	112	$230
Government	8,844	$425	Government	13,193	$2,018	Government	1,975	$199
Total	**55,195**	**$564**	**Total**	**101,129**	**$860**	**Total**	**15,779**	**$274**

1/ Assumes that all ACA provisions are fully implemented. Costs include total expected health care spending PMPM in 2014 but should not be confused with premium, since important items such as administrative costs, taxes, and risk mitigation programs are not included.

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Provider Payment Levels

The HBSM model adjusts payment levels for individuals simulated to move from Medicaid to commercial insurance and from commercial insurance to Medicaid. This is done using state-level Medicaid physician fees relative to Medicare (KFF StateHealthFacts), national Medicare physician fees relative to commercial insurance (MedPAC) and hospital payment to cost ratios for Medicaid relative to commercial insurance (The Lewin Group estimates).

However, health care for the uninsured is currently paid for by a variety of sources including out-of-pocket, free from hospitals and clinics, other indigent care programs and funding sources, Worker's Compensation, and other private sources such as automobile insurance. Provider payment levels may vary for all these different sources and there is no standard approach for determining how each of these payment levels compares to payment levels by Medicaid or commercial insurance. Therefore, we do not attempt to modify payment levels for the newly insured in the HBSM model but show the potential increase in their health care utilization as they become insured and the associated spending for that increased utilization.

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Chair:
Kenny Kan, FSA, MAAA and

Members:
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The authors would also like to thank the actuaries and researchers who provided over twenty seven pages of comments on our draft report. The comments and observations could be broken down into three main categories. The first category was requests for clarification of terms used and what was being described. Wherever possible, we have added additional clarification throughout the report to address those comments. The second category included professional edits, often around semantics, and to be more precise. For example, our reference to "current law" as meaning approaches in effect prior to 2014, even though ACA is actually "current law." However, the main provisions addressed in this report just haven't been implemented yet. Rather than re-doing labels in hundreds of tables, we just define what we meant by the terms we used. The third category included concerns and even disagreement with some of the assumptions used in our model and concerns that the results in tables were not always a smooth curve as one would expect if building tables. For example, there are costs at some age groupings that are higher than the next highest age grouping, a result seldom seen in actuarial tables. Our approach in displaying model results was to avoid any "editing" of results to make results appear smoother. We have left that to the readers of the report so that they can decide on the level of smoothness and assumptions to be made in so doing. We would expect actuaries to have different assumptions regarding such an important issue that is being modeled. In client situations, we are able to change assumptions based on client input, but for this study, we used our baseline assumptions and have documented them so that the reader is aware. However,

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sensitivity testing of key assumptions is outside the scope of the project.

Based on the comments, we offer some general considerations when using this report. First, actual per member per month figures generally should not be used, but instead focus on the change in figures. Readers will need to make important assumptions regarding possible pent-up demand in 2014 and 2015 and initial enrollment forecasts for the first two years will also have to be assumed and may be subject to wide variation based on assumptions for each state. Generally, smoother results are desirable and looking at other "similar" states may provide another input in to so doing. State specific results may be too broad for most analysis, generally, for client work, we provide results at smaller county or groupings of counties level. There will be differences between results from this report and other reports, and the reader should consider some of the likely reasons for that by reading documentation to the extent it is available. Regulations have continued to be produced, whereas the output of the model in this report was frozen as of late September. Therefore, regulations that have come out since, especially those in late November, 2012, are not reflected (though most of those impact premium calculations which are not a major focus of this report). A model must make general assumptions on premium determinations and cannot duplicate all of the nuances of pricing in such a dynamic state. That said, it is our belief that the subsidies will be the most important consideration to take into account.

We hope that this report will help the reader in addressing issues that will be very important in preparing for 2014 and beyond.

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Appendix A – Assumptions for Modeling Coverage Changes Under the ACA

This Appendix describes the data and assumptions used to model each of these key decision points. These analyses were developed using The Lewin Group Health Benefits Simulation Model (HBSM), which is a micro-simulation model of the U.S. healthcare system, designed to provide estimates at the national, state and county levels. The model has been developed over a period of 22 years to estimate the impacts of major changes in the health care system such as the recently enacted Patient Protection and Affordable Care Act (ACA). The model provides estimates of changes in coverage and health spending for the federal government, states, private employers, consumers and providers.

The key to the model is a representative sample of households reporting sources of health insurance coverage, income, employment status, family relationship, demographic characteristics and health spending by source of payment and type of service. The basic data sources are the Medical Expenditure Panel Survey (MEPS) conducted by the Agency for Healthcare Research and Quality and the Current Population Survey (CPS) conducted by the Bureau of the Census. The model also incorporates the American Community Survey (ACS) which is a large household survey that makes it possible to provide estimates at the county and sub-county levels (for large counties only).

Figure A-1 presents a flow chart showing each key decision point in the model. A central element of the analysis is modeling the premiums for the coverage available to individuals and the amount of the subsidies and penalties they face in deciding whether to take coverage. A key element of the process is a detailed simulation of premiums in the individual and small group markets under the premium setting and underwriting practices that apply in each state. Thus the outcome of the employer decisions affects the choices available to individuals.

The following sections describe the baseline data and assumptions used to model changes in coverage and costs under the ACA. A more detailed documentation of the HBSM model can be found at http://www.lewin.com/publications/publication/413/.

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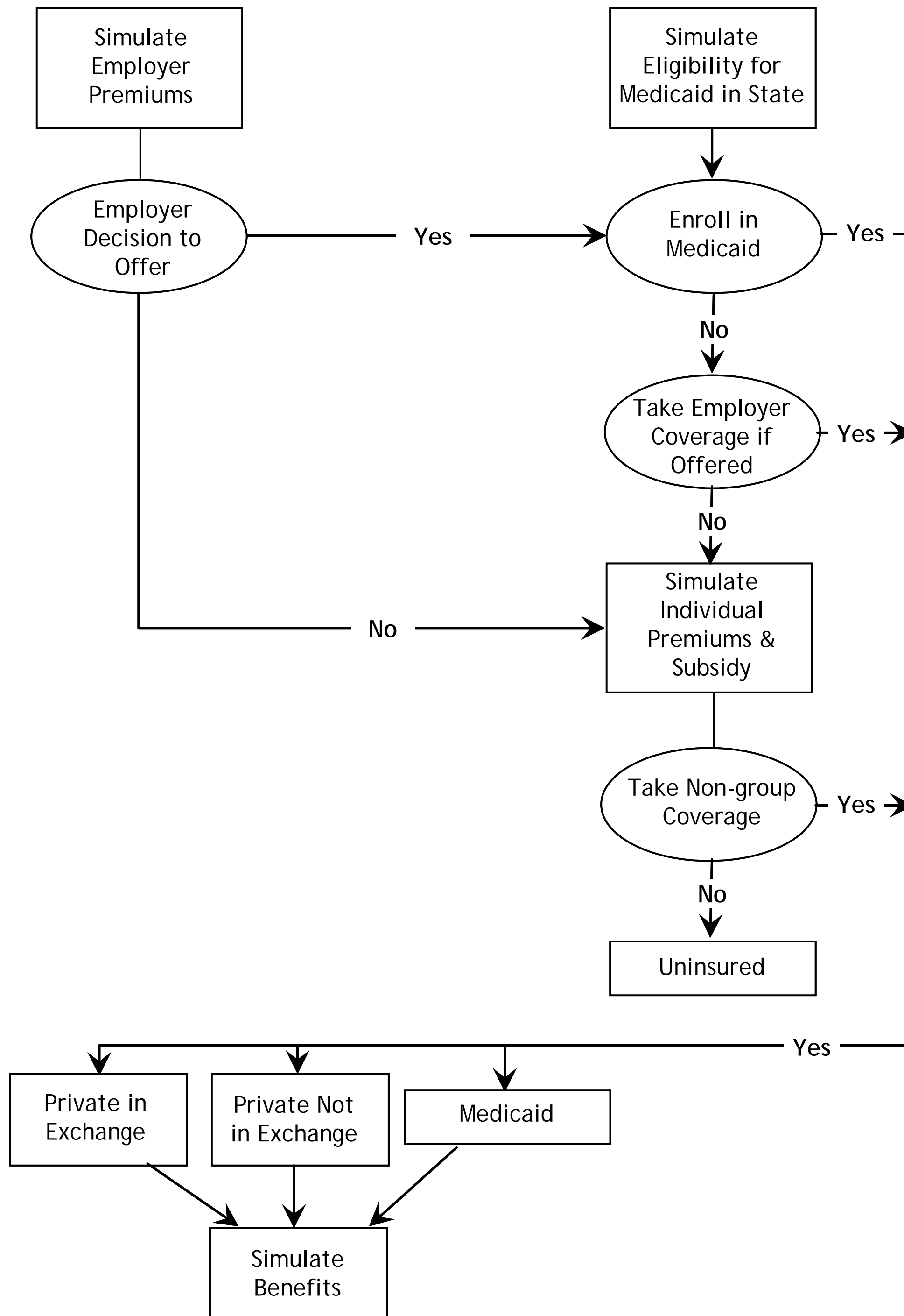
Figure A-1: HBSM Simulation Flowchart for modeling ACA



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A. Development of Baseline Data

HBSM operates on a database of households that are matched to a database of synthetic employers. The model is based upon the pooled Medical Expenditures Panel Survey (MEPS) data for 2002 through 2005. These data provide information on sources of coverage and health expenditures for a representative sample of the population. These data were adjusted to reflect the population and coverage levels reported in the 2008-2010 Current Population Survey (CPS) data. We pooled three years of CPS data in order to increase the sample size at the state level.

We chose the MEPS data because it is the only data source that provides both the detailed income and coverage detail we need together with detailed information on health conditions, health service utilization and spending. These data have enabled us to develop a model that simulates premiums endogenously, including risk selection effects. It also enables us to model policies affecting "uninsurable" populations and simulate the effects of benefits design.

We develop a sample of employers based upon two employer surveys. We statistically match the 2006 KFF survey of employers with the 1997 RWJF Survey of employers. The KFF data provide information on health plan characteristics, while we rely upon the RWJF data to provide information on the demographic characteristics of people working within each employer. Workers in the household data are statistically matched to an employer in the employer database so that we have detailed information on each worker's employer and health plan if present.

Household Data

The HBSM baseline data are derived from a sample of households that is representative of the economic, demographic and health sector characteristics of the population. HBSM uses the 2002-2005 MEPS data to provide the underlying distribution of health care utilization and expenditures across individuals by age, sex, income, source of coverage, and employment status. We then re-weighted this database to reflect population control totals reported in the 2008-2010 March CPS data.

We make adjustments to the CPS to account for the under-reporting of Medicaid coverage and use these data to estimate the number of uninsured for the entire year, as designed by the CPS. The count of uninsured all year in the MEPS data is adjusted to match the CPS estimate. The result of the methodology produces an average monthly count of uninsured in our model of 52.4 million nationally in 2014, which is similar to the CBO estimate of the average monthly number of uninsured. However, estimates of uninsured at the state-level will appear higher than other sources, which are based on the CPS definition of full year uninsured.

These weight adjustments are done with an iterative proportional-fitting model, which adjusts the data to match approximately 250 separate classifications of individuals by socioeconomic status, sources of coverage, and job characteristics in the CPS. Iterative proportional fitting is a process where the sample weights for each individual in the sample are repeatedly adjusted in a stepwise fashion until the database simultaneously replicates the distribution of people across each of these variables in each state. The population weights are then projected to 2014 using U.S. Census Bureau population projections to account for population changes by age and sex for each state between 2010 and 2014.

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Once the MEPS data are re-weighted for population and coverage, we adjust the health expenditure data reported in the MEPS database for each state. These data are adjusted to reflect projections of the health spending by type of service and source of payment in the base year (i.e., 2014). These spending estimates are based upon state-level health spending data provided by CMS and detailed projections of expenditures for people in Medicare and Medicaid across various eligibility groups. Spending data for the employer market are based on average premiums published in the MEPS Insurance Component data by firm size and state. We also adjust spending for the non-group market using state-by-state premium data obtained from the National Association of Insurance Commissioners' 2010 Supplemental Health Care Exhibit Report and projected cost for people in current state and temporary federal high-risk pools.

The result is a database that is representative of the base year population in each state by economic and demographic group, which also provides extensive information on the joint distribution of health expenditures across population groups.

Employer Database

The model includes a database of employers for use in simulating policies that affect employer decisions to offer health insurance. We use the 2006 survey of employers conducted by the KFF. These data include about 3,000 randomly selected public and private employers with 3 or more workers, which provide information on whether they sponsor coverage, and the premiums and coverage characteristics of the plans that insuring employers offer. However, because the KFF data do not include information on the characteristics of their workforce, we match the KFF data to the 1997 RWJF survey of employers, based upon firm characteristics and the decile ranking of the actuarial value of health plans in each database given coverage and cost-sharing features of each plan.

While dated, the RWJF data provide a unique array of information on the demographic and economic profile of their workforce. Thus, we rely upon the KFF data for information on health benefits, but rely upon the RWJF data for the distribution of each employer's workforce by full-time/part-time status, age, gender, coverage status (eligible enrolled, eligible not enrolled and ineligible), policy type (i.e., single/family); and wage level. However, these data do not provide detailed information on worker health status and health spending required to simulate the effect of policies affecting group insurance rating practices and other behavioral responses.

To be able to simulate these aspects of reform, we develop a "synthetic" database of firms that, includes detailed health status and spending information for each worker and dependent in the firm. The first step is to statistically match each MEPS worker, which we call the "primary worker", with one of the employer health plans in the 2006 KFF/RWJF data. We then populate that firm by randomly assigning other workers drawn from the MEPS file with characteristics similar to those reported for the KFF/RWJF database.

For example, a firm assigned to a given MEPS worker that has 5 employees would be populated by that worker plus another four MEPS workers chosen at random who also fit the employer's worker profile. If this individual is in a firm with 1,000 workers, he/she is assigned to a Kaiser/HRET employer of that size and the firm is populated with that individual plus another 999 MEPS workers. This process is repeated for each worker in the HBSM data to produce one unique synthetic firm for each MEPS worker (about 63,000 synthetic firms). Synthetic firms are

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created for all workers including those who do not sponsor health insurance, and workers who do not take the coverage offered through work.

Thus, if a firm reports that it employs mostly low-wage female workers, the firm tended to be matched to low-wage female workers in the MEPS data. This approach helps assure that RWJF/Kaiser/HRET firms are matched to workers with health expenditure patterns that are generally consistent with the premiums reported by the firm. This feature is crucial to simulating the effects of employer coverage decisions that impact the health spending profiles of workers going into various insurance pools.

Month-by-Month Simulation

HBSM simulates coverage on a month-by-month basis. This is necessary because economic conditions and coverage vary over the course of the year. These changes can lead to changes in eligibility for public programs and can greatly affect the cost of proposals to expand coverage. Moreover, eligibility for Medicaid and SCHIP is determined on a monthly income basis. Failure to account for these transitions over the course of the year can lead to errors in estimating program impacts by omitting periods of part-year eligibility.

The household database used in HBSM is organized into 12 separate months. The MEPS data identify sources of insurance coverage by month for each individual in the survey. Thus, for example, an individual could be uninsured for five months and covered under Medicaid for the next seven months. These data also include information on employment status at certain times of the year which can be used to approximate the months in which each person is employed, particularly for people reporting employer coverage (which is reported by month). Earnings income, which is reported on an annual basis, is allocated across these months of employment. The individual health events data provided in MEPS also enables us to identify health services utilization in each month, which is important in allocating health spending to months of coverage by source.

B. State-level Simulation of Insurance Markets

One of the most important features of the ACA is its sweeping reforms of insurance and premium rating practices. HBSM includes models of insurance markets in each state. The model simulates the widely varying rating methodologies used within each state for the non-group market and employer groups.

Group Rating Practices

We model premiums for each synthetic firm in the insurance markets based upon the small group rating rules in each state and reported health expenditures for the workers assigned to each plan. This includes community rating, age rating, and rating bands. Experience rating based upon reported health expenditures for the workers assigned to each firm is also used for fully insured plans where permitted (usually for mid-sized firms). We also estimate premiums for self-funded plans based upon the health services utilization for people assigned to each firm.

We simulate these rating practices by developing a “rating book” for each state based upon the rating factors allowed in each state. In many states, premiums may vary widely by age, industry, gender and health status. This information is available for each worker and dependent

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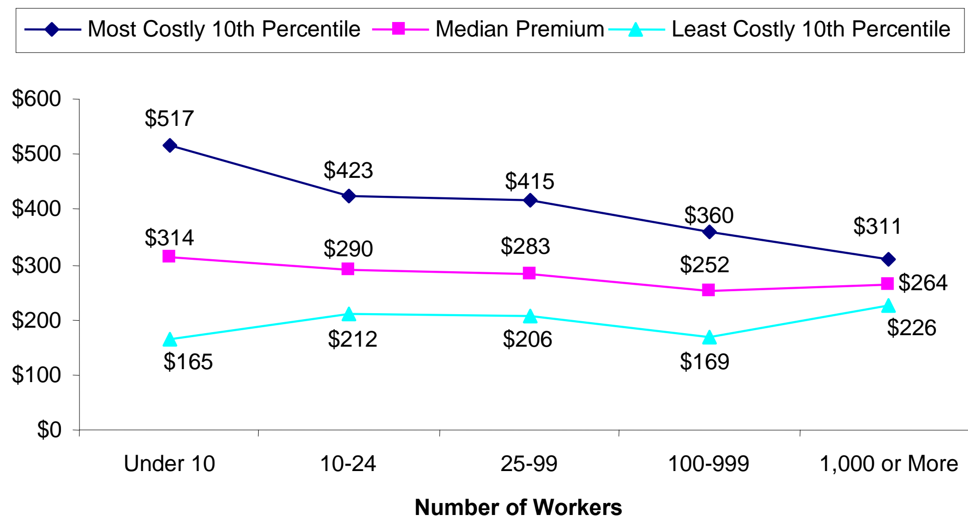
assigned to each of the firms in the database. Health status rating is simulated by identifying individuals in the file with chronic conditions and high expected costs, given their reported level of utilization in the prior year. We developed separate rating books for each state that limits rate variation by age or health status.

States typically define the small group market as firms with 50 or fewer workers. We simulate premiums for larger fully insured firms based upon estimates of expected costs based on reported spending in the prior year. For self-funded plans, premiums are assumed to equal per-worker costs by family type. In addition, we simulate premiums for all employers, including those that do not offer coverage, so we can simulate uptake of coverage as premiums are changed due to reform.

Figure A-2 illustrates that the variability in PMPM premium costs varies widely across employers by size of group. For example, among firms with fewer than 10 workers, PMPM premiums range from about $460 for firms in the 10 percent most costly firms compared with average costs of $157 for firms in the 10 percent least costly firms. By comparison, PMPM premiums in firms with 1,000 or more workers vary from $372 for the 10 percent most costly groups to $215 for the least costly 10 percent of firms. Assuring this range of variability is preserved in the data is essential to modeling reforms that can have large effects for small numbers of firms.

Figure A-2: Estimated Average Health Insurance Costs (PMPM) for Most Costly and Least Costly 10 Percent of Employer Groups in 2006: Includes Benefits and Administration [a/]



a/ Estimates for a standard benefits package.
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Because these premiums are estimated for a uniform benefits package, it is necessary to perform a final adjustment to reflect the actual provisions of the plan offered by individual employers. We do this by estimating the actuarial value of each plan using the coverage and cost sharing data reported in the KFF employer data. We then adjust the premium estimated for the plan by the ratio of the actuarial value of the employer's plan and the actuarial value of the standard benefits package used in the analysis.

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Individual Insurance Market Simulation Model

HBSM also includes a model of the individual insurance market. The model defines the non-group insurance markets to include all people who are not otherwise eligible for coverage under an employer plan, Medicare, Medicaid or TRICARE (i.e., military dependents and retirees). The model simulates premiums for individuals using the rules that prevail in each state. Premiums can be varied by age, gender and health status. This is done by compiling a "rate book" based upon the HBSM health spending data for the state reflecting how costs vary with individual characteristics.

We simulate health status rating in the individual market in states where this is permitted. In these states, the premiums that individuals pay reflect the claims experience of the group or some other indication of worker health status. We simulated these premiums using a "tiered rating" process that classifies people into several risk levels based upon expected health spending based upon prior year health expenditures.

In most states, insurers are permitted to deny coverage to people with health conditions. Thirty-three states have a high risk pool available to those who cannot obtain coverage due to their health condition. We simulate this by selecting a portion of the population reporting in MEPS that they had a chronic health condition and are also covered under a non-group plan. The conditions we used to identify "uninsurable" individuals are based upon the condition lists used in several states to identify people as eligible for the high risk pool. We also identify uninsurable people among the uninsured.

C. State-level Model of Medicaid and CHIP

The Model simulates a wide variety of changes in Medicaid and the Children's Health Insurance Programs (CHIP) eligibility levels for children, parents, two-parent families, and childless adults. The model simulates certification period rules, deprivation standards (i.e., hours worked limit for two-parent families), "deeming" of income from people outside the immediate family unit and other refinements in eligibility. As under the program, the model simulates eligibility on a month-by-month basis to estimate part-year eligibility.

HBSM estimates the number of people eligible for the current Medicaid program and various eligibility expansions using the actual income eligibility rules used in each state for Medicaid and SCHIP. The model simulates enrollment among newly eligible people based upon estimates of the percentage of people who are eligible for the current program who actually enroll. In addition, it simulates the lags in enrollment during the early years of the program as newly eligible groups learn of their eligibility and enroll.

1. Simulating Medicaid Eligibility and Enrollment

Because the MEPS data do not report the state of residence, Medicaid simulations in HBSM begin with the CPS data. We simulate the number of people eligible for expansions in coverage using the 2008-2010 CPS data. The CPS includes the detailed data required to simulate eligibility for the program including income by source, employment, family characteristics and state of residence. These results are integrated into the MEPS data in HBSM in a later step described below.

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It is necessary to allocate reported income across months to perform month-by-month simulations. We do this by allocating reported weeks of employment across the 52 weeks of the year according to the number of jobs reported for the year. Reported weeks of unemployment and non-participation in the labor force are also allocated over the year. We then: distribute wages across the weeks employed; unemployment compensation over weeks unemployed; workers compensation income over weeks not in labor force. Other sources of income are allocated across all 12 months of the year.

Using these data, we can estimate the number of program filing units (single individuals and related families living together) who meet the income eligibility requirements under the current program in their state of residence. The model also simulates the number of people who would be eligible under proposed increases in income eligibility. In particular, the model can estimate the number of non-custodial adults who are eligible under expansions affecting these groups.

Eligibility for the Medicaid expansion is restricted to legal U.S. residents that have been resident in the US for at least five years. However, undocumented immigrants are not eligible for the Medicaid expansion. Legal immigrants that have been in the country for five or less years are ineligible for the Medicaid expansion. To model this requirement, we impute undocumented status and length of time living in the U.S. for people in our HBSM model using citizenship and length of time living in the U.S. as reported in the CPS, which is then controlled to national estimates by the Pew Hispanic Center. [16] Since the CPS data is state specific, it provides the information necessary to estimate the number of undocumented and legal immigrants living in the U.S. for five or fewer years at the state level.

Once estimated, we incorporate our Medicaid expansion estimates into the MEPS based household data for each state. We do this by simulating eligibility in the adjusted state-specific MEPS data based on monthly income, age and family type. New eligibility and enrollment is calibrated to replicate the CPS based estimate.

2. Individual Decision to Enroll in Medicaid and CHIP

We simulated the decision for newly eligible people to enroll in the Medicaid expansion based upon a multivariate model of enrollment in the existing program which reflects differences in enrollment by age, income, employment status, and demographic characteristics. The simulation results in average enrollment of about 75 percent of newly eligible uninsured people and 39 percent for newly eligible people who have access to employer health insurance. HBSM simulates eligibility on a month-by-month basis to capture part-year eligibility for the program.

We assume that currently eligible but not enrolled children will be enrolled as a newly eligible parent becomes covered under Medicaid. Also, we assume that eligible families will enroll in instances where the parent loses employer coverage because their employer decides to discontinue their health plan (discussed above). We also simulated a small increase in enrollment due to the penalty for Medicaid eligible people with income high enough to be required to pay taxes (people with incomes below the income tax filing threshold ineligible under the Act).

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[16] Gretchen Livingston, "Hispanics, Health Insurance and Health Care Access", September 2009.

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We assume that in states that currently provide coverage to adults above 138 percent of FPL will discontinue that coverage in 2014 when subsidies become available and move these people into the exchanges. [17] We assume that CHIP is continued and states do not move children above 138 percent of FPL into the exchanges but continue the CHIP program.

Based upon these analyses, our estimated take-up rates average 25 to 74 percent, as shown in ***Figure A-3***:

Figure A-3: Individual Decision to Take Medicaid

	HBSM Estimate
Newly eligible without access to employer coverage:	74%
Newly Eligible with access to employer coverage:	39%
Currently eligible and uninsured who enroll:	25%

D. Individual Decision to Take Private Non-Group Coverage

For people not eligible for Medicaid, we model the decision for uninsured individuals to take non-groups coverage based upon a multivariate model of how changes in the price of insurance affect the likelihood of taking coverage. In addition, we model the decision for insured individuals to discontinue their coverage in cases where their premium increases using the same multivariate model.

Eligibility for premium subsidies is restricted to legal U.S. residents regardless of the length of time they have resided in the country. However, undocumented immigrants are not eligible for premium subsidies within the Exchanges. Legal immigrants that have been in the country for five or less years are ineligible for the Medicaid expansion but would be eligible for premium subsidies if their income is below 400 percent of FPL. To model this requirement, we impute undocumented status and length of time living in the U.S. for people in our HBSM model using citizenship and length of time living in the U.S. as reported in the CPS, which is then controlled to national estimates by the Pew Hispanic Center. Since the CPS data is state specific, it provides the information necessary to estimate the number of undocumented and legal immigrants living in the U.S. for five or fewer years at the state level.

1. Decision for Uninsured to Take Non-Group Coverage

For each individual/family, we estimate the cost of insurance under prior law and again under the act. These premiums reflect:

1. Prior law premium includes the cost of insurance for the individual in the individual market under the rating rules that apply in their state of residence;

[17] States that currently offer coverage to adults above 138% FPL include CT, DC, IL, ME, MN, NJ, NY, RI, TN, VT and WI.

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2. Premiums under the act include the cost of insurance under community rating less premium subsidies in the exchange; and
3. The effect of the tax exclusion for health benefits on the after tax cost of coverage.

We estimate the likelihood of taking the coverage based upon the difference in premium before and after the act using a premium elasticity averaging about -3.4. This means that on average a one percent reduction in premium corresponds to a 3.4 percent increase in the number of people taking coverage.

The effect of the mandate is simulated on the basis of the penalty the individual/family would pay under the act if they remain uninsured. We treat the penalty as an increase in the cost of remaining uninsured, which has the effect of reducing the net new cost of taking coverage under the act.

Figure A-4 presents HBSM estimates of the percentage of uninsured people taking individual coverage by expected claims costs and family income:

Figure A-4: Uninsured Individual Decision to Take Private Coverage (with subsidy and penalty effect)

Expected Claims Costs	Family Income Level			
	Under $25,000	$25,000-$50,000	$50,000-$75,000	$75,000 or more
	HBSM Estimate	HBSM Estimate	HBSM Estimate	HBSM Estimate
$0 to $1,000	76%	39%	27%	19%
$1,000 to $10,000	93%	68%	49%	16%
$10,000 or more	94%	86%	58%	51%
Uninsurable Diagnosis	91%	79%	58%	37%

1/ Many survey respondents in the MEPS data that we identify as having an uninsurable condition have expected spending less than $10,000 per year.

2. People with Non-Group Insurance who Discontinue Coverage

We also simulate discontinuations of coverage for people experiencing an increase in their Non-group premium. The model calculates the premium for covered people as described above, which reflects changes in premiums due to rating changes, premium subsidies and the penalty they would pay (penalties are treated as a reduction in the cost of being uninsured which reduces the net cost of obtaining coverage).

For those facing a net increase in premium costs we simulate the likelihood of discontinuing coverage using the multivariate model described above (Average price elasticity of -.3.4). HBSM estimates of people discontinuing non-group coverage are shown in ***Figure A-5*** by percent change in premium and expected health spending.

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Figure A-5: Percentage of People with Non-Group Insurance who Discontinue Coverage

Percent Change Premium	Expected Claims Costs			
	$0 to $1,000	$1,000 to $10,000	$10,000 or more	Uninsurable
	HBSM Estimate	HBSM Estimate	HBSM Estimate	HBSM Estimate
50% or more	65%	49%	0	0
25% to 50%	38%	16%	0	0
10% to 25%	10%	6%	0	0
-10% to 10%	1%	0	0	0
-10% to -25%	0	0	0	0
-25% to -50%	0	0	0	0
-50% or more	0	0	0	0

n/a – Assumes people with reductions in price do not discontinue coverage.

3. *Individual Decision to Purchase Coverage through the Exchange*

We use a series of assumptions to estimate the number of people taking non-group coverage who will be enrolled in the exchange. These assumptions include:

1. Anyone taking individual coverage that is eligible for premium subsidies will purchase coverage in the exchange. This is because subsidies are available only for people participating in the exchange.
2. People currently purchasing non-group coverage who are not eligible for subsidies will remain with their current plan outside the exchange.
3. All uninsured people not eligible for subsidies that take individual coverage will take coverage through the exchange.

Using these assumptions, the percentage of people taking coverage in the exchange is zero to 100 percent, as shown in ***Figure A-6***:

Figure A-6: Individual Decision to Purchase Coverage through the Exchange

	Lewin Assumption
People qualifying for premium subsidies:	100%
People who now have non-group coverage but do not qualify for subsidies:	0%
People who are uninsured and deciding to take non-group coverage but do not qualify for subsidies:	100%

E. Individual Decision to Take-up Existing Employer Coverage

Using the MEPS and Bureau of the Census data, we estimate that there are up to six million uninsured people who have been offered health insurance from an employer but have declined

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the coverage. These include uninsured workers and any uninsured spouses and children who could have been covered as dependents. This also include uninsured dependent children whose parent has taken coverage for his/her self but has not elected the family coverage option. These people are likely to have declined coverage because they have difficult affording the required premium contribution.

In response to the mandate, many of these workers are expected to take the coverage offered by their employer to avoid paying the penalty. We simulate the decision to take coverage using the multivariate model of the decision to take coverage given the change in the price of coverage under the Act. As discussed above, this model yields an overall average price elasticity of -3.4, although this varies with the characteristics of the individual.

The price of coverage to the worker is defined to be the share of the employer premium paid by the worker under reform compared with the employer premium the worker would pay under current policy. This allows us to model the effect of changes in premiums resulting from health insurance rating reforms in smaller firms. In addition, we count the amount of the penalty they would pay for remaining uninsured under the Act (unless exempt from the mandate) as an increase in the cost of being uninsured which has the effect of reducing the net cost to the individual of taking the employer's plan.

Figure A-7 presents HBSM estimates of the percentage of uninsured workers taking employer coverage by change in premium and size of employer:

Figure A-7: Uninsured Workers Who Have Declined Employer Coverage under Current Law Who Take That Coverage as a Result of the Mandate

Rate Change (Includes Premium Changes and Subsidies)	Group Size	
	Under 200	200 or more [a/]
	HBSM Estimate	HBSM Estimate
50% or more	5%	0%
25% to 50%	13%	0%
10% to 25%	1%	0%
-10% to 10%	36%	26%
-10% to -25%	16% [b/]	0%
-25% to -50%	27% [b/]	0%
-50% or more	NA	0%

a/ Under the Act, firms with 200 or more workers are required to use automatic enrollment.
b/ sample size may be too small to provide reliable results.

F. Employer Decision to Start Offering Coverage

We model the employer decision to provide coverage based upon multivariate models of how changes in the price of insurance affect the likelihood of offering coverage. We model the employer decision to offer coverage in the following two steps:

- Based on change in net cost of coverage; and

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- Based on changes in worker demand for coverage.

1. Changes in Net Cost of Coverage to Employer

The likelihood of offering coverage is dependent upon several factors including the price for insurance. The ACA will change the price of insurance to employers in three ways:

1. New small employer tax credits;
2. Changes in premium due to community rating in firms with higher cost workers; and
3. A New Penalty for employers who do not offer insurance.

HBSM estimates the change in premiums for each employer for coverage under the law. We do this by simulating the premiums each employer will face under current practices and under the insurance rating rules under the Act. In general, younger and healthier people will pay more for coverage while older and less health people will pay less. We also reflect the amount of the small employer tax credit they would qualify for to estimate net premium costs. We Model the effect of the penalty for not offering coverage as an increase in the cost of being uninsured, which reduces the net cost of providing coverage.

We model the decision to offer coverage using is a multivariate model of how changes in premiums affect the likelihood of offering coverage. The price elasticity varies from -0.87 for small firms to less than -0.20 for large firms. This means that a one percent reduction in premiums results in a 0.87 percent increase in the number of small firms offering coverage.

Figure A-8 presents HBSM estimates of the percentage of employers who decide to offer coverage due to price changes (including subsidy and penalty effects) by the percentage change in premiums (including subsidy effects) and group size.

Figure A-8: Employers Who Decide to Offer Coverage Due to Price Changes by Change in Premiums and Group Size

Rate Change (Includes Premium Changes and Subsidies)	Group Size		
	2 to 50	50-100	100 or more
	HBSM Estimate	HBSM Estimate	HBSM Estimate
50% or more	0%	0%	n/a
25% to 50%	0%	0%	n/a
10% to 25%	0%	4%	n/a
-10% to 10%	3%	17%	59%
-10% to -25%	14%	26%	n/a
-25% to -50%	25%	58%	n/a
-50% or more	38%	0%	n/a

N/A – No firms in Cell under ACA.

2. Changes in Worker Demand for Coverage

The requirement for people to have insurance coverage will increase the demand for employer sponsored insurance. Uninsured workers who now face a penalty for not having coverage will want to obtain that coverage at the lowest possible price, which will often be employer insurance. Employer coverage is generally less costly to administer because of the economies of

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scale in selling and administering coverage for a group. Premium payments for employer health benefits are also tax exempt, which increases the value of employer insurance to the individual as compared with individual coverage.

The model simulates the decision for employers to start offering coverage as a result of the individual penalty for being without coverage. As discussed above, we treat the individual penalty as an increase in the cost of going without insurance that effectively reduces the net cost of taking coverage for the group. We use this as an estimate of the economic benefit to individuals in the group if the employer were to offer coverage.

We model the employer decision based upon the multivariate model of the likelihood of taking coverage as the price of insurance changes as described above. This model shows an average price elasticity of -0.34, which means that a one percent reduction in the net cost of insurance results in 0.34 percent of affected employers offering coverage. Firms are assumed to offer coverage only if employer insurance is less costly than non-group coverage with premium subsidies.

In this analysis, the number of people taking coverage is determined on the basis of the change in price attributed to the individual penalty only (the impact of other factors affecting premiums is modeled in other steps described in this document.) Thus, a health reform program with no penalty for being without coverage has no impact on the number of employers offering coverage.

Figure A-9 presents HBSM estimates of the percentage of non-insuring firms that decide to offer coverage due to increased worker demand for coverage, based on these assumptions.

Figure A-9: Employer Decision to Start Offering Coverage Due to Increased Worker Demand for Coverage (worker weighted)

Average Earnings of Workforce	Group Size		
	2 to 50	50-100	100 or more
	HBSM Estimate	HBSM Estimate	HBSM Estimate
Less than $30,000	2.8%	1.2%	5.1%
$30,000- $50,000	7.1%	1.1%	5.3%
$50,000- $75,000	10.4%	5.9%	9.3%
$75,000 or more	16.4%	n/a	23.2%

n/a – due to small sample size we expect immaterial results.

G. Employer Decision to Discontinue Coverage

Some employers who now offer insurance will decide to discontinue that coverage under the ACA. This will occur among employers seeing an increase in premiums under the Act. We also expect some insuring employers to discontinue coverage in cases where their workers can obtain subsidized coverage through the exchange at a lower cost. These employer decisions are modeled in two steps:

- Employers dropping coverage due to increase in the net cost of coverage; and

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- Employers dropping coverage in response to subsidies for individual coverage.

1. Employers Dropping Coverage due to Increase in the Net Cost of Coverage

In this step, we assess the impact of changes in the cost of insurance to the employer on the number of employers offering coverage. Employer health insurance premiums will be affected by changes in rating practices under the Act. In general, employers with younger and healthier workforces will see premiums increase while employers with older and less healthy individuals will see premiums reduced. In addition, the small employer tax credit will reduce premium costs for some firms.

We use HBSM to estimate the change in net premium costs for employers under the Act. We also estimate the penalty for not offering coverage, which we treat as an increase in the cost of not offering coverage, which has the effect of reducing the net cost of obtaining insurance.

We model the decision to offer coverage using is a multivariate model of how changes in premiums affect the likelihood of offering coverage. The implicit price elasticity varies from -0.87 for small firms to less than -0.20 for larger firms. This means that a one percent reduction in premiums results in a 0.87 percent increase in the number of small firms offering coverage.

Figure A-10 shows HBSM estimates of the percentage of employers who decide to discontinue coverage due to price changes (including subsidy and penalty effects) by group size and percentage change in premium (including subsidy effects).

Figure A-10: Employer Decision to Discontinue Coverage Due to Changes in Net Premium (worker weighted)

Rate Change (Includes Premium Changes and Subsidies)	Group Size		
	2 to 50	50-100	100 or more
	HBSM Estimate	HBSM Estimate	HBSM Estimate
50% or more	18%	0%	n/a
25% to 50%	21%	11%	n/a
10% to 25%	15%	8%	n/a
-10% to 10%	1%	1%	0%
-10% to -25%	0%	0%	n/a
-25% to -50%	0%	0%	n/a
-50% or more	0%	0%	n/a

N/A – No firms in Cell under ACA.

2. Employers Dropping Coverage in Response to Subsidies for Individual coverage

Some employers may discontinue coverage under health reform because their workers become eligible for free or subsidized coverage in the exchange. Because these subsidies are available only to people without access to employer coverage, the employer must discontinue its plan for the workers to get these subsidies.

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We model this by:

1. Estimating the number of insuring employers where workers can obtain coverage at a lower cost in the exchange (reflecting any change in premium resulting from community rating); and
2. Estimating the percentage of these firms that discontinue coverage.

We model the employer decision to discontinue coverage based upon a multivariate model of how changes in the price of alternative health coverage affect the likelihood of switching to the alternative source of coverage. The plan switching elasticity is -2.54, which means that a one percent lower premium results in 2.54 percent of employers discontinuing coverage so workers can obtain subsidize coverage in the exchange.

Figure A-11 presents HBSM estimates of the percentage of employers discontinuing coverage due to the availability of subsidized non-group coverage by average worker earnings and group size.

Figure A-11: Employer Decision to Discontinue Coverage due to Availability of Subsidized Non-group Coverage in the Exchange (worker weighted)

Average Earnings of Workforce	Group Size		
	2 to 50	50-100	100 or more
	HBSM Estimate	HBSM Estimate	HBSM Estimate
Less than $30,000	24%	24%	8%
$30,000- $50,000	6%	1%	4%
$50,000- $75,000	3%	1%	2%
$75,000 or more	1%	0%	1%

H. Employer Decision to Offer Coverage in the Exchange

Some employers are permitted to provide coverage for their workers through the exchange. This means that the employer will pay a premium to the exchange and allow the workers to select one of the plans offered in the exchange. This differs from a scenario where employers simply decide not to offer coverage.

Initially, only firms with 100 or fewer workers are eligible to offer coverage for their workers through the exchange in this way. Under the act, these workers are not eligible for subsidies because the employer is contributing to the cost of their insurance.

We assume that premiums in the exchange are about four percent less costly than premiums for coverage sold outside the exchange because of reduced reliance on insurance agents and brokers, who typically receive a commission on sales. Aside from this, the act requires that insurer premiums outside the exchange must be the same as inside the exchange.

We simulate the shift of employers from their current health plan to coverage offered in the exchange based upon the plan switching elasticity of -2.54 discussed above. This means that a

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one percent reduction in premium results in 2.54 percent of employers shifting their coverage to the exchange. We also assume that employers that qualify for the premium tax credits would take coverage in the exchange since these credits will only be available through the exchange.

HBSM estimates of the percentage of employers shifting to the exchange are presented in ***Figure A-12***.

Figure A-12: Employer Decision to Offer Coverage in the Exchange

	HBSM Estimate
Firms with fewer than 50 workers:	45%
Firms with 50 to 100 workers:	4%
Firms with over 100 workers (ineligible	0%

I. Utility Function Model

For this study, we also used a "utility" function to provide sensitivity analyses around our results. The utility function has been used by several researchers to simulate how consumer choice of insurance coverage is affected by both financial factors, uncertainty and consumer aversion to risk.[18,19,20] The utility function provides a "score" measuring the benefit to an individual of taking a given insurance product. The score includes the amount of the premium less expected health care costs, plus a valuation of the value to the consumer of protection from unexpected health care costs based upon the Arrow-Pratt model of absolute risk aversion. This approach has also been used to model take-up of insurance under health reform by Pauly and Herring, and Eibner and Girosi.[21]

For each individual in the model, we calculated the utility score for taking insurance under each of the five benefits packages ($U_{i,j}$). We estimate for each person the expected level of spending based upon their health status and health spending reported in MEPS. For each individual, we estimate expected total spending, expected out-of-pocket spending if insured and the variance in expected health care costs. The methods used to estimate these expected cost values are presented in the following section and are illustrated in ***Figure A-13*** below.

We calculate the utility score separately for each of the five benefits packages that would be available in the exchange (i.e., Bronze, Silver, Gold, Platinum and Catastrophic if eligible) based upon expected spending levels and the cost-sharing provisions of each plan. We also calculate a utility score for being uninsured. People are assumed to select among the six possible coverage

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[18] Pauly, M., Herring, B., "Expanding Coverage Via Tax Credits: Trade-offs and Outcomes," *Health Affairs*, 20, no. 1 (2001): 9-26.

[19] Pauly MV., and Herring, BJ., "An Efficient Employer Strategy for Dealing with Adverse Selection in Multiple-Plan Offerings: an MSA Example," *Journal of Health Economics*, 19 (2000)

[20] See: Pauly, MV., Herring, B., Song D., "Tax Credits, the Distribution of Subsidized Health Insurance Premiums, and the Uninsured, " *Forum for Health Economics & Policy*, Vol. 5, no. 5, 2002; and Eibner, C., et al., "Establishing State Health Insurance Exchanges: Implications for Healthy Insurance Enrollment, Spending, and Small Businesses," (report to the Department of Labor), RAND Corporation, 2010.

[21] Christine Eibner, et al, "Establishing State Health Insurance Exchanges: Implications for Health insurance, Enrollment, Spending and Small Businesses," RAND, 2010.

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states (i.e., five benefits packages or uninsured) based upon whichever coverage state yields the highest utility score given the individual's unique expectation of health spending.

We estimate utility scores for coverage under each of the benefits packages that will be available in the exchange using the following equation.

$$(1_j) \qquad U_{i,j} = -E(OOP_{i,j}) - NPrem_{i,j} - 0.5rVar(OOP_{i,j}) + Uhealth_i$$

Three of these values are imputed to individuals from the data shown above in ***Figure A-13***. These include:

> $E(OOP_{i,j})$ is expected out-of-pocket health spending if insured under benefits package $_j$ (column 4, ***Figure A-13***);
>
> $Var(OOP_{i,j})$ is the variance in expected out-of-pocket spending if insured under benefits package $_j$ (column 5, ***Figure A-13***, squared); [22]
>
> $Uhealth_i$ is a measure of the utility of health services consumed, which we assume is equal to the value of total expected health care costs for the individual if insured under all five benefits packages (column 2, ***Figure A-13***);[23] and
>
> $NPrem_{i,j}$ is the net premium defined to be premiums less subsidies that we compute separately for each unique policyholder in the model for each of the five benefits packages.

Where:

> i= Individual in the simulation; and
>
> j= Alternative benefits packages.

We assume the coefficient for "r" is the midpoint of various Arrow-Pratt absolute risk aversion coefficients (.00084) published in studies of consumer risk aversion for unexpected health spending used by other authors.[24]

In setting these utility values we include the patient cost-sharing subsidies that would be provided under the Act for income eligible individuals. Under the ACA, the exchange will buy-up an individual's benefits package (with a supplemental premium payment) to increase the actuarial value of the plan to levels shown in ***Figure A-14***. Thus, for example, the utility of the Silver benefits package is greatly enhanced for those who are eligible for subsidies.

---

22 As discussed above, the ACA alters the risk of going without coverage by prohibiting insurers from implementing pre-existing condition exclusions. We model this effect by assuming that the variance in out-of-pocket spending is reduced for people who do not have chronic conditions. The variance is equal to standard deviation squared.

23 Estimates assume a level of spending consistent with an individual who has health insurance. This measure does not include an estimate of consumer surplus.

24 See: Friedman, B., "Risk Aversion and Consumer Choice of Health Insurance Option," *Review of Economics and Statistics*, Vol. 56, May 1974; Marquis, MS., and Holmer, MR., "Choice under Uncertainty and the Demand for Health Insurance," The Rand Corporation, N-2516-HHS, 1986; and, Manning, WG., and Marquis, MS., "Health Insurance: The Trade-Off Between Risk Pooling and Moral Hazard," (Report to the National Center for Health Services Research and Health Care Technology Assessment), December 1989.

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We then calculate the utility score for going without insurance (U_n) using a similar formula:

(2) $U_n = -E(OOP_n) - \text{penalty} - 0.5rVar(OOP_n) + Uhealth_n$

Here, we estimate spending for people if uninsured using the expected spending data imputed to each policy-holder from ***Figure A-13*** below, reduced by one-third to reflect the lower levels of spending without insurance. This is based upon more conservative CBO estimates of increased spending for the uninsured. The values in the second equation include:[25]

> $E(OOP_n)$ is the expected value of out–of-pocket spending without insurance which we assume is equal to total expected health spending if insured (column 2, ***Figure A-13***) reduced by one-third;
>
> $Var(OOP_n)$ is the variance in expected out-of-pocket spending, which for the uninsured is equal to expected total health spending without insurance. We assume this is equal to the variance in expected total spending if insured (column 3, ***Figure A-13*** squared) reduced by one-third;
>
> Penalty is the dollar amount of the penalty an individual or family would pay if they go without insurance; and
>
> $Uhealth_n$ is the expected total amount of spending if uninsured, which we assume to be equal to total spending for the insured (column 2, ***Figure A-13***) reduced by one-third.

For these calculations, we use expected spending amounts for each person, including one for expected spending while insured and a second while uninsured. Thus, the utility function while uninsured reflects the lost utility of reduced health spending due to a lack of coverage. The methods we use to do this are described in the following section.

1. Expected Health Care Costs

The key elements of this analysis are our estimates of expected health spending and the variance in expected health spending for each policy holder in the data. We develop these estimates based upon subsamples of the MEPS data for 2005 through 2007 that provide information on spending for each individual for two consecutive years. These data permit us to estimate average expected health spending at the beginning of the year based upon each individual's reported health spending in the prior year. This results in expectations of spending that vary with health status, as approximated by prior year health spending. These data also enable us to estimate expected out-of-pocket costs and the variance in total expected spending used in our utility function (***Figure A-13***).[26]

---

[25] We used a list of about 50 health conditions to identify people in the MEPS with a chronic condition based upon the ICD-9 condition codes in these data. This list is based upon the lists of health conditions currently used to determine eligibility for existing high risk pools in Colorado, Tennessee and Texas. Using the MEPS, we estimate that there are about 9.9 million uninsured people who have one or more of the pre-existing conditions that typically result in denial of coverage or a "rating-up" of premiums in these markets.

[26] The model imputes spending in the prior year based upon spending in the survey period for those who do not report spending data for two consecutive years.

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Figure A-13: Average Cost Per Person in Two Consecutive Years by Percentile Ranking of First Year Spending at 2011 Spending Levels: Privately Insured Only

Percentile of Year 1 Cost per Person	(2010) Year 1 Total Spending	(2011) Year 2			
		Expected Total Spending	Standard Deviation of Expected Total Spending	Expected Out-of-Pocket	Standard Deviation of Out-of-pocket Spending
10 Percent	$0	$949	$4,685	$206	$858
20 Percent	$95	$1,225	$8,038	$215	$696
30 Percent	$286	$1,498	$6,907	$261	$659
40 Percent	$514	$1,661	$5,223	$389	$1,089
50 Percent	$835	$2,247	$6,001	$446	$889
60 Percent	$1,329	$2,879	$6,425	$591	$1,105
70 Percent	$2,130	$3,618	$7,731	$757	$1,147
80 Percent	$3,594	$4,798	$8,353	$1,027	$1,688
90 Percent	$6,605	$7,076	$13,720	$1,252	$1,707
95 Percent	$11,894	$9,267	$16,070	$1,520	$2,054
97.5 Percent	$19,865	$13,080	$22,933	$1,792	$2,529
98.75 Percent	$30,991	$18,084	$30,983	$2,666	$4,476
100 Percent	$81,910	$39,450	$57,158	$3,158	$6,974
Average	$4,043	$4,105	$12,405	$708	$1,611

a/ Data is based upon the MEPS for 2004-2005, 2005-2006, and 2006-2007. We adjusted these data to correct for an undercount of people with the very highest expenditures, based upon actuarial data for people in commercial health plans.
Source: The Lewin Group Estimates using the Health Benefits Simulation Model (HBSM).

These data reveal the expected "regression to the mean." That is, people with the highest expenses in the first year tend to have lower expenses in the next year, while people with little expense in the first year have higher costs in the following year. For example, an individual receiving heart bypass surgery can be expected to have high health expenditures in that year, but costs in the following year will tend to be lower as they recover. Similarly, people with little or no spending in a given year may become ill and start to make greater use of the system in the second year.

As discussed above, we use expected spending amounts for each person, including one for expected spending while insured and a second while uninsured. We estimate these amounts in the following steps:

- Currently uninsured: For people who were uninsured in the MEPS survey, we used reported spending to estimate spending levels while uninsured. To estimate spending for these people while insured, we adjusted these spending amounts to match health spending reported by insured people with similar demographic and health status characteristics. These estimate costs are then used to estimate what expected spending levels would have been at the beginning of the year as illustrated in ***Figure A-13***.
- Currently Insured: We assumed that health expenses while insured are assumed to be the same as they reported in the MEPS. We estimated spending while uninsured by adjusted these amounts to reflect the lower levels of spending reported by uninsured people with similar characteristics. These estimates of costs were then used to estimate

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what expected spending levels would have been at the beginning of the year as illustrated in Figure 13.

2. *Alternative Benefits Packages*

As discussed above, for each individual, we calculate a utility score for each of the coverage options available through the exchange. These include the Bronze, Silver, Gold, Platinum and Catastrophic package (available for people under age 30 only). The services covered under the Bronze, Silver, Gold and Platinum packages are the same; they differ only in terms of point-of-service cost sharing. These packages are denoted in terms of "actuarial value," where a plan that covers all of these services without patient cost sharing would have an actuarial value of 1.0.

The Bronze benefits package is to have an actuarial value of 0.6, which means that the cost sharing parameter (deductibles and copayments) are set at the level required to on average cover 60 percent of the cost of covered services. The actuarial value increases with each succeeding level of coverage to 0.7 for Silver, 0.8 for Gold, and 0.9 for the Platinum package. In ***Figure A-14***, we present actuarial values of each plan. We assume that the Catastrophic plan, which is available to only people under age 30 or people facing premiums under the Bronze package that exceed 9.5 percent of income, would cover the same services with cost sharing calibrated to an actuarial value of 0.5.

Figure A-14: Example Co-payments Meeting Actuarial Standards under ACA: Illustrative Estimates for 2011 [a/]

	Actuarial Value
Benefit Packages in the Exchange	
Platinum Package	.90
Gold Package	.80
Silver Package	.70
Bronze Package	.60
Bronze Small Employer	.60
Catastrophic	.50
Cost Sharing Subsidy Health Plans	
Less than 150% FPL	.94
150% to 200% FPL	.87
200% to 250% FPL	.73
250% to 400% FPL	.70

a/ The Act also reduces the maximum out-of-of pocket spending limits by income level.

Source: The Lewin Group Estimates using the Health Benefits Simulation Model (HBSM).

3. *Accounting for Risk Factors under the ACA*

We model the effect of open enrollment and pre-existing condition exclusions based upon their effect on risk to the individual for going uninsured. The challenge in using this function is estimating the perceived risk of going without insurance under the ACA. For elimination of the mandate to cause the premium spiral that many expect, the perceived risk of going without insurance must be low enough that many relatively healthy people feel comfortable going without coverage. But if the perceived risk of going uninsured is high, we should see little coverage loss from lifting the mandate.

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The ACA alters the financial risk of going without coverage by prohibiting insurers from imposing pre-existing condition exclusions. If not for the annual open enrollment period, this would permit people to delay taking coverage until they need services without fear of pre-existing condition exclusions. This could ignite the premium spiral that many fear if the mandate is eliminated. However, under the ACA, the individual would not be able to take that coverage for up to 11 months until the annual open enrollment period, which retains for the individual substantial risk for going without insurance.

We assume that people reporting a chronic health condition in the MEPS have high perceived risk of going without coverage which we account for by using 100 percent of the variance in expected health costs as a measure of perceived risk.[27,28] For people who did not report a chronic health condition, we assume that they consider themselves to be at risk for accidents and emergency care if uninsured. Based upon data from the Agency for Healthcare and Quality (AHRQ), about 34 percent of all hospital admissions for the commercially insured population originate in the emergency room.[29] Based on this estimate, we use 34 percent of the variance in total expected health spending as a proxy for perceived risk for these individuals.

4. *Simulation of the ACA*

We estimate the number of people taking coverage under the ACA as written using the methodology described above. People are assumed to choose the coverage option that yields the highest utility score given their expected health spending and eligibility for subsidies. Thus, an individual is assumed to go uninsured if the utility score for being uninsured is greater than the utility scores for the five health plans. Alternatively, individuals are simulated to take one of the five health plans (four if over age 30) with the highest utility score. Older and sicker people tend to elect plans with higher actuarial values, while younger and healthier people tend to enroll in less comprehensive coverage.

We calibrate the model to reflect estimates of the impact of the ACA on coverage using the probability/elasticity-based methodology described in prior sections. Specifically, we calibrate baseline results under the ACA to replicate the estimates of the number of people remaining uninsured that the model generates using the probability models described above at the national level. However, the demographic and health status distributions of the newly insured vary under the two models. Upon reviewing the simulations, we found that the results were sufficiently similar such that we ultimately calibrated the utility model only for non-subsidy-eligible people who would have had non-group coverage under prior law.

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27 See: Pauly, MV., Herring, B., Song D., "Tax Credits, the Distribution of Subsidized Health Insurance Premiums, and the Uninsured, " Forum for Health Economics & Policy, Vol. 5, no. 5, 2002; and Eibner, C., et al., "Establishing State Health Insurance Exchanges: Implications for Healthy Insurance Enrollment, Spending, and Small Businesses," (report to the Department of Labor), RAND Corporation, 2010.

28 We used a list of about 50 health conditions to identify people in the MEPS with a chronic condition based upon the ICD-9 condition codes in these data. This list is based upon the lists of health conditions currently used to determine eligibility for existing high risk pools in Colorado, Tennessee and Texas. Using the MEPS, we estimate that there are about 9.9 million uninsured people who have one or more of the pre-existing conditions that typically result in denial of coverage or a "rating-up" of premiums in these markets.

29 See: Owens, P., and Elixhauser, A., "Hospital Admissions That Began in the Emergency Department, 2003," Agency for Healthcare Research and Quality, February 2006.

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5. *Allowing for Downgrades in Coverage*

An important aspect of this simulation is that it models both discontinuations of coverage and downgrades in coverage resulting from increases in premiums. We anticipate that eliminating the mandate will increase premiums enough that many people will discontinue coverage. However, for some of these individuals, the utility score for less comprehensive coverage will continue to be greater than the utility of going without insurance, even at the higher premium levels. In our simulations, these individuals are assumed to downgrade their coverage to a less comprehensive plan rather than simply becoming uninsured.

For example, someone simulated to purchase the Silver plan under the ACA may respond to the premium increase by purchasing the Bronze plan. In our simulations, this will happen in cases where the utility score of the Bronze plan for that individual is still greater than the utility score for going uninsured.

Allowing for coverage downgrades has the effect of reducing our estimates of coverage loss due to the elimination of the mandate because some of these individuals will move to a lower-cost health plan rather than actually going uninsured.

6. *Sensitivity Analysis*

Because utility functions are driven by the assumptions, it is important to test the sensitivity of the estimates to alternative assumptions. There is evidence that a substantial portion of the uninsured see themselves as "risk-averse." Data from the 2007 Health Tracking Household Survey conducted by the Center for Studying Health System Change (HSC) indicate that 49.6 percent of uninsured people with "No Health, Medical Bill or Access Problems" report themselves to be risk-averse.[30] Thus the risk of being uninsured for medical emergencies may motivate many of the uninsured to obtain coverage, particularly if premium subsidies are available. Consequently, we performed sensitivity analysis that incorporates alternative measures of consumer risk and risk aversion.

Some risk-averse individuals may decide to continue purchasing coverage to protect against catastrophic health care costs, even though they expect to spend less than the premium amount. The use of open enrollment periods would heighten this sense of risk. Conversely, many people have little idea of what their expected spending will be in the coming year, since people cannot predict medical emergencies.

In this study, we performed two sensitivity analyses of the utility function to model potential adverse selection into the non-group market. The first assumes that people are one-third less risk-averse (meaning that healthier people are more likely to assume the risk of going uninsured) and a second scenario that assumes people are two-thirds less risk averse. This was done by changing the Arrow-Pratt risk aversion coefficient for "r" in the utility function from 0.00084 to 0.00054 to model one-third less risk aversion and 0.00028 to model two-thirds les risk aversion.

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[30] Cunningham, P., "Who Are the Uninsured Eligible for Premium Subsidies in the Health Insurance Exchanges", The Center for Studying Health System Change, No. 18, December 2010.

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J. Estimating Health Spending for Newly Insured

The MEPS data report that health services utilization for uninsured people is substantially less than among insured people. The data show physicians' visits per 1,000 people are about 1,349 for the uninsured compared with 3,283 for insured people. Also, hospital stays for the insured are more than double that of the uninsured. Part of the difference in utilization rates is due to the fact that the uninsured are on average younger than insured people. Consequently, we adjust for this when estimating how utilization would change for this population as they become insured.

We assume that uninsured people who become covered under a coverage expansions proposal would use health care services at the same rate reported by currently insured people with similar age, sex, income and health status characteristics. This assumption encompasses two important effects. First, the increase in access to primary care for this population would result in savings due to a reduction in preventable emergency room visits and hospitalizations. Second, there would be a general increase in the use of elective services such as primary care, corrective orthopedic surgery, advanced diagnostic tests, and other care that the uninsured either forego or delay.

1. Modeling Pent-up Demand for Newly Insured

The research on "pent-up" demand for health care services as people become newly insured has shown mixed results. A study of near elderly uninsured who are approaching Medicare eligibility found that pent-up demand exists for physician care, but not for hospital inpatient care. The study estimated that the people who were uninsured prior to Medicare enrollment have 30 percent more physician visits during the two years after Medicare enrollment than their previously insured counterparts. [31] Another study of the near-elderly indicate that the increased utilization experienced after age 65 by those who were uninsured prior to Medicare lead to an elevated hazard of diagnosis (relative to the insured) for virtually every chronic condition considered, for both men and women and the magnitudes of these effects are clinically meaningful. [32]

However, other study findings have been inconclusive as to the extent of pent-up demand. One study of children newly enrolled in Medicaid found no evidence of pent-up demand for medical care among newly insured children, when they were compared to children who had been continuously insured. [33] Another study examined the effects of the Oregon Medicaid lottery after approximately one year of insurance coverage. The study presented estimates of the impact of insurance coverage, using the lottery as an instrument for insurance coverage,

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[31] Li-Wu Chen, Wanqing Zhang, Jane Meza, Roslyn Fraser, MA, "Pent-up Demand: Health Care Use of the Uninsured Near Elderly", Economic Research Initiative on the Uninsured Working Paper Series, July 2004

[32] Schimmel, Jody. "Pent-Up Demand and the Discovery of New Health Conditions after Medicare Enrollment" Paper presented at the annual meeting of the Economics of Population Health: Inaugural Conference of the American Society of Health Economists, TBA, Madison, WI, USA, Jun 04, 2006

[33] K. Goldsteen, R.L. Goldsteen, "Demand For Medical Services Among Previously Uninsured Children: The Roles of Race and Rurality", South Carolina Rural Health Research Center, Arnold School of Public Health, University of South Carolina, October 2002

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found no evidence of a larger initial utilization effect, suggesting that such "pent up" demand effects may not in fact be present. [34]

Our baseline estimates for the effects of the ACA do not include an adjustment for pent-up demand in our HBSM modeling due to the mixed study findings.

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[34] Amy Finkelstein et. al., "The Oregon Health Insurance Experiment: Evidence from the First Year ",

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Appendix B – The HBSM Rate Book Description

The purpose of this document is to present the "rating book" used to simulate premiums for individuals and firms in the individual and small employer markets. For modeling purposes, we compute an individual market premium for all individuals and family units in HBSM (regardless of whether they are currently covered) using the current rating rules in each state. We also compute a premium for each unit using the rating restrictions under the ACA. Both premiums are based on a standard benefits package and are used to model coverage changes due to changes in the price of insurance. Similarly, we estimate premiums for each of our "synthetic groups" in HBSM, which are described below, using the current rating rules in each state and the rating restrictions under the ACA. Our "Methods and Key Assumptions for Modeling Cost of Newly Insured Under the ACA" document describes how these premiums are used to model changes in coverage.

Our "rate book" is actually a series of adjustment factors that are applied to a base rate to determine a premium for an individual or group. Our practice is to estimate a "base rate" for policy holders in each risk pool defined by markets and legislation using HBSM, such as the individual market. Using the spending data provided in HBSM, we estimate separate base rates for single policy holders and family policy holders, which include dependent costs.

These rates are then used to estimate a premium for each policy holder simulated to be in a given risk insurance pool using HBSM. For each policy holder in the pool, we multiply the base rate by a series of adjustments for risk factors included in the rating process, subject to state laws and regulations. The use of rating factors varies by state, primarily due to differences in state laws governing the rating process.

However, the rating factors used may differ by insurer. For example, insurers often have the option to rate by industry and other factors, subject to the laws that apply in the state. In these cases, we use information on the prevalence of the use of individual rating factors in the industry to determine its use in the simulation model.

The rating factors themselves are estimated from the Medical Expenditures Panel Survey (MEPS) data using health spending amounts for all privately insured individuals in the data. These data form the basis of rate setting in the individual and small group markets. Premiums are ultimately adjusted to reflect actual health spending for privately insured people nationally as estimated by the Office of the Actuary of the Centers for Medicare and Medicaid Services (CMS).

In the first section, we present the approach used to simulate rating in the individual market within HBSM. In the second section, we present the methods used to model premiums for firms in the small group market. The third section describes our method for simulating enrollment and costs for individuals in high-risk pools. The final two sections present our approach to simulating premiums in the individual and small group markets under the ACA.

A. Individual Market under Current Law

The model simulates premiums for people in the individual market using the rating factors that apply in their state of residence. The rating factors included age, gender, and an "expected loss

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ratio," which we use as a proxy for health status rating information in states where health status may be used in the rating process.

The key steps in the process include:

- Identification of "uninsurable" people;
- Age and gender adjustment;
- Estimation of expected costs;
- Health status adjustment; and
- Special rates for uninsurable people.

1. Identification of Uninsurable Individuals

We use the MEPS data to estimate the number of people with chronic health conditions that would be classified as uninsurable by an insurer. The MEPS data include detailed information for each health condition reported by individuals in the survey. This permits us to identify health conditions using ICD-9 condition codes reported in these data at the three-digit level.

We used a list of about 69 health conditions to identify someone as uninsurable. This list is based upon the lists of health conditions currently used to determine eligibility for existing high risk pools in 19 states. [35] We included conditions that were on eligibility lists in at least 5 states. Using the MEPS, we estimate that there are about 9.9 million uninsured people who have one or more of the pre-existing conditions that typically result in denial of coverage or a "rating-up" of premiums in these markets.

2. Estimation of Expected Costs for Population

In most states, rating in the individual market reflects a certain degree of medical knowledge of the applicant that is generally used to adjust premiums for health status. Insurers can obtain this information based upon health spending in the prior year or through medical underwriting questionnaires for new applicants. In this analysis, we estimate "expected health spending at the beginning of the year for which rates are being determined. This estimate of expected costs is based upon health spending for each individual in the MEPS data.

The MEPS provides spending information for each individual in the survey for over 24 months. This enables us to estimate average spending in a year based upon their spending in the prior year. ***Figure B-1*** presents average spending in the second year based upon their percentile ranking of their spending in the prior year.

[35] States include AK, CO, IA, KY, MD, MN, MT, NE, NC, ND, NH, NM, OK, OR, TN, TX, WA, WV and WY.

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Figure B-1: Average Cost Per Person in Two Consecutive Years by Percentile Ranking of First Year Spending at 2010 Spending Levels: Privately Insured Only

Percentile of Year 1 Cost per Person	(2010) Year 1	(2011) Year 2
10 Percent	$0	$749
20 Percent	$134	$865
30 Percent	$337	$1,057
40 Percent	$614	$1,522
50 Percent	$1,023	$1,998
60 Percent	$1,706	$2,920
70 Percent	$2,774	$3,669
80 Percent	$4,777	$4,541
90 Percent	$9,375	$7,121
95 Percent	$15,663	$11,379
97.5 Percent	$25,096	$12,511
98.75 Percent	$38,282	$18,590
100 Percent	$210,600	$31,065
Average	$3,851	$3,940
Median	$995	$910

Source: The Lewin Group Estimates using the Health benefits Simulation Model (HBSM).

These data reveal the expected "regression to the mean." That is, people with the highest expenses in the first year tend to have lower expenses in the next year. For example, an individual receiving heart by-pass surgery can be expected to have high health expenditures in that year. However, costs in the following year will tend to be lower than the prior year as these individuals recover. Similarly, people with little or no spending in a given year may become ill and start to make greater use of the system in the second year.

These data are used to provide a projection of the average expected level of spending for each individual in the coming year based upon their percentile ranking of spending in the prior year. We then convert these data to an "expected loss ratio," which is defined as total expected health spending over the base rate for a given benefits package.

3. State Rating Regulations

We use data compiled by the National Association of Health Underwriters (NAHU) on state regulations for the individual market as the basis for determining rating methods in the model. Based upon these rules, we identify seven types of state rating scenarios that apply, depending upon the rate variation permitted in a state. These include:

- Uninsurable individual in states permitting medical underwriting;
- +/- 50% rating bands;
- +/- 30-35% rating bands;
- +/- 20-30% rating bands;
- Adjusted community rating; and

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- Pure community rating.

In states that do not have significant rating restrictions, we assume that individuals are rated on single year of age, gender and expected loss ratio for each individual (***Figure B-2***). In states with rate band limits of 50 percent or more, we assume that rates vary by age and loss ratio subject to a 4:1 limit. Rate bands on age and expected loss ratio of 3:1 are used in state with rating bands of 30 to 50 percent. In states that specify rating bands of less than 30 percent, we assume rate bands on age of 3:1.

Figure B-2: Rate Tables by Type of State Regulation [a/]

	Age Rating	Loss Ratio
1: no rating structure	Single Year	4:1
2: +/- 50% rating bands	4:1	4:1
3: +/- 30-35% rating bands	4:1	3:1
4: +/- 20-25% rating bands	3:1	2:1

a/ Separate approach is used for "uninsurable" people as described below.

For community rates states, the premium is equal to the base rate. In states with adjusted community rating (rate variation by age only), we assume premiums are set according to a 4:1 rating band by age. Health status and expected loss ratios are not used in community rated states.

A separate set of rating rules is used for people deemed to be "uninsurable" because they have pre-existing chronic health conditions. For uninsurable people with high health care costs in the prior year, we use expected health costs as the basis for setting the premium. These rating methods are described below in greater detail. *Figure B-3* presents a summary of the rating rules in the individual market by state.

Figure B-3: State Rating Regulations for the Individual Market

State No	State Name	Rating Limit	High Risk Pool
1	Alabama	1: NRS: no rating structure	1
2	Alaska	1: NRS: no rating structure	1
3	Arizona	1: NRS: no rating structure	0
4	Arkansas	1: NRS: no rating structure	1
5	California	1: NRS: no rating structure	1
6	Colorado	1: NRS: no rating structure	1
7	Connecticut	1: NRS: no rating structure	1
8	Delaware	1: NRS: no rating structure	0
9	Dist of Columbia	1: NRS: no rating structure	0
10	Florida	1: NRS: no rating structure	1
11	Georgia	1: NRS: no rating structure	0
12	Hawaii	1: NRS: no rating structure	0

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State No	State Name	Rating Limit	High Risk Pool
13	Idaho	2: +/- 50% rating bands	1
14	Illinois	1: NRS: no rating structure	1
15	Indiana	1: NRS: no rating structure	1
16	Iowa	2: +/- 50% rating bands	1
17	Kansas	1: NRS: no rating structure	1
18	Kentucky	3: +/- 30-35% rating bands	1
19	Louisiana	1: NRS: no rating structure	1
20	Maine	5: ACR: adjusted community rating	0
21	Maryland	1: NRS: no rating structure	1
22	Massachusetts	5: ACR: adjusted community rating	0
23	Michigan	1: NRS: no rating structure	0
24	Minnesota	4: +/- 20-25% rating bands	1
25	Mississippi	1: NRS: no rating structure	1
26	Missouri	1: NRS: no rating structure	1
27	Montana	1: NRS: no rating structure	1
28	Nebraska	1: NRS: no rating structure	1
29	Nevada	2: +/- 50% rating bands	0
30	New Hampshire	4: +/- 20-25% rating bands	1
31	New Jersey	6: C: pure community rating	0
32	New Mexico	1: NRS: no rating structure	1
33	New York	6: C: pure community rating	0
34	North Carolina	1: NRS: no rating structure	1
35	North Dakota	1: NRS: no rating structure	1
36	Ohio	1: NRS: no rating structure	0
37	Oklahoma	1: NRS: no rating structure	1
38	Oregon	5: ACR: adjusted community rating	1
39	Pennsylvania	1: NRS: no rating structure	0
40	Rhode Island	1: NRS: no rating structure	0
41	South Carolina	1: NRS: no rating structure	1
42	South Dakota	3: +/- 30-35% rating bands	1
43	Tennessee	1: NRS: no rating structure	1
44	Texas	1: NRS: no rating structure	1
45	Utah	3: +/- 30-35% rating bands	1
46	Vermont	6: C: pure community rating	0
47	Virginia	1: NRS: no rating structure	0
48	Washington	5: ACR: adjusted community rating	1
49	West Virginia	3: +/- 30-35% rating bands	1
50	Wisconsin	1: NRS: no rating structure	1
51	Wyoming	1: NRS: no rating structure	1

Source: National Association of Health Underwriters (NAHU)

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4. Age and Gender Rating Factors

Most states permit rating by age and in many cases gender. However, the degree of premium variation within these rating factors is often limited by state law. Consequently, we develop age rating adjustment by single-year of age and under increasingly more narrow age rating bands from 4:1 to 3:1 and do not include gender rating.

The age adjustments are estimated from the MEPS data for privately insured people. For states with no rating restrictions, we assume that premiums vary with individual year of age and gender (***Figure B-4)***. We use a "smoothing" technique to eliminate spurious variation in rates from one year's age to the next. ***Figure B-5*** presents the age rating factors assuming alternative rating bands apply by age. We simplify this process by creating wider age bands, which has the effect of reducing the variation in adjustment factors.

These adjustments are performed separately for individual policy holders and family policy holders. The model uses a base rate for individuals and a base rate for family coverage, both of which vary with the age of the policyholder only.

Figure B-4: Age Rating by Single-year of Age

Age	Individuals		Family	
	Male	Female	Male	Female
17	0.4869	0.6008	0.4016	1.6568
18	0.4469	0.5868	0.5579	1.5048
19	0.4503	0.6320	0.8402	1.2249
20	0.4303	0.8518	1.0727	0.8905
21	0.4403	0.9057	1.0727	0.7201
22	0.4503	0.9640	1.1487	0.6747
23	0.4476	0.9989	1.0530	0.7020
24	0.4576	1.0664	0.9027	0.7068
25	0.4662	1.3368	0.8242	0.7227
26	0.4762	1.2984	0.8106	0.7676
27	0.5000	1.2995	0.8773	0.7805
28	0.5120	1.2711	0.9247	0.7490
29	0.5243	1.2457	0.9284	0.7200
30	0.5368	1.2937	0.8832	0.8285
31	0.5497	1.3247	0.8832	0.8285
32	0.5629	1.3564	0.8881	0.8530
33	0.5815	1.4013	0.9053	0.8271
34	0.6007	1.4475	0.9153	0.7442
35	0.6225	1.1780	0.9838	0.6967
36	0.6423	1.2155	1.0953	0.6761
37	0.6622	1.2531	1.2067	0.6761
38	0.6887	1.3033	1.2071	0.6868
39	0.7152	1.3534	1.1226	0.7012
40	0.7450	1.2852	1.0025	0.7448
41	0.7748	1.2556	0.9341	0.7900

Age	Individuals		Family	
	Male	Female	Male	Female
42	0.8046	1.2260	0.9069	0.8208
43	0.8377	1.2015	0.9033	0.8508
44	0.8741	1.1820	0.9119	0.8656
45	0.9105	1.1092	0.9021	0.8906
46	0.9503	1.1423	0.9208	0.8464
47	0.9900	1.1754	0.9533	0.7726
48	1.0430	1.2085	1.0383	0.6960
49	1.0960	1.2416	1.0771	0.6681
50	1.1522	1.2747	1.0888	0.6642
51	1.2152	1.3112	1.1270	0.6298
52	1.2781	1.3476	1.2501	0.6008
53	1.3476	1.3973	1.4569	0.6252
54	1.4204	1.4469	1.5695	0.7218
55	1.4966	1.4966	1.6303	0.8404
56	1.5794	1.5496	1.5560	0.9069
57	1.6621	1.6059	1.5217	0.9273
58	1.7548	1.6688	1.4037	0.9276
59	1.8542	1.7350	1.3323	0.9605
60	1.9568	1.8045	1.2751	1.1107
61	2.0661	1.8740	1.3481	1.4748
62	2.1820	1.9502	1.5066	2.1395
63	2.2945	2.0197	1.7577	2.9443
64	2.4137	2.0926	2.1359	3.6889
65	2.8144	2.3277	2.6246	4.2686

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Figure B-5: Age Rating Factors in States with Rate Bands by Age

	Individual	Family
States with Age Adjustment Limited to 4:1 Rate Band		
< 20	0.5737	1.0426
20-24	0.6646	0.8932
25-29	0.6712	0.8165
30-34	0.8899	0.8566
35-39	0.8856	0.9603
40-44	1.2239	0.8895
45-49	1.5479	0.9085
50-54	1.4842	1.0865
55-59	1.4457	1.3230
60+	2.2627	2.0021
States with Age Adjustment Limited to 3:1 Rate Band		
< 25	0.6355	0.9190
25-34	0.7517	0.8407
35-44	1.0635	0.9234
45-54	1.5191	0.9704
55+	1.9144	1.5726

5. Health Status Adjustment

The final step is to adjust the age and gender rated premium estimated above to reflect the health status of the individual. We use the model to create a "loss ratio" for each individual, that is computed as the ratio of expected costs for an individual over the age and gender rated premium discussed above.

Each premium is then multiplied by an expected loss ratio that adjusts for differences in the expected level of spending for the individual that is not explained by the age adjustment. We did this by applying the age and gender premium for each individual in MEPS and computing the ratio of expected costs to the age and gender adjusted premium, which we have called the loss ratio.

We then tabulate all privately insured people in the MEPS by various groupings of the expected loss ratio to create factors for use in simulating the rating process. To simulate the limits on rate variation in the individual markets, we create separate groupings that have the effect of limiting rate variation to 4:1, 3:1 and 2:1 (***Figure B-6***).

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Figure B-6: Rate Variation with Expected Loss Ratio

Loss Ratio: 4:1 Rate Band	
0-50	0.4944
50-75	0.8730
75-100	0.9874
100-125	1.0967
125-150	1.1829
150+	1.8891
Loss Ratio: 3:1 Rate Band	
0-75	0.6447
75-100	0.9874
100-125	1.0967
125+	1.5543
Loss Ratio: 2:1 Rate Band	
0-100	0.7964
100-115	1.0876
115+	1.4344

This enables us to simulate the effect of limitations on rate variation. For example, for a state with a 4:1 rating band, the model uses loss ratio adjustments ranging between 0.4944 and 1.8891. The loss ratio factor varies from 0.6447 to 1.5543 in a state limiting rate variation to 3:1.

6. Special Rates for Uninsured people with Chronic Conditions (Uninsurable)

In this step, we assign a premium to uninsured individuals representing what they would have to pay for coverage given their health status. This amount is computed even for people in states where insurers are permitted to decline coverage to individuals due to health status. These individual are assigned a risk adjustment based upon the amount of their expected spending. Uninsurable people who are in the 90th percentile or more of the general population in terms of prior year spending are assigned a loss ratio adjustment factor that is equal to their computed loss ratio. Because people in the uninsurable group generally have higher costs than others, many of the uninsurable people have spending at or above the 90th percentile (***Figure B-7***).

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Figure B-7: Rating for Uninsurable Individual [a/]

Uninsurable People – At or Above the 90th Percentile on prior year Health Spending	
Below 90th percentile	1.8891
95th percentile	2.8881
97.5th percentile	3.1754
98.75th percentile	4.7183
100th percentile	7.8881
Insurable People – Below 90th Percentile on Prior Year Spending by Expected Loss Ratio Group	
0-50	0.4944
50-75	0.8730
75-100	0.9874
100-125	1.0967
125-150	1.1829
150+	1.8891

a/ Uninsurable individuals are defined to be people with one or more chronic conditions that are typically used in states to identify people eligible for a state high-risk pool.

For uninsurable people below the 90th percentile in prior year spending, we adjust the premium based upon a 4:1 rating band based on their expected loss ratio.

B. Small Group Rating under Current Law

We simulate rating practices in the small group market using a "synthetic" firm database. These data are based upon a survey of employers from the Kaiser Family Foundation survey of employers which we have statistically matched to a sample of workers from the MEPS household data that obtain the detailed health spending and demographic data required to simulate the impact of small group rating practices, including the detailed data required on each member of the employer's workforce.

The process used to simulate premiums in the small group market is similar to that used to simulate individual premiums, except that it is at the firm level. We develop a "rate book" methodology that simulates premiums under the methods permitted in each state, including health status rating. This enables us to simulate the changes in premiums that will result from changes in rating practices mandated in health reform.

The methods we use to simulate small group premiums are presented in the following sections:

- Synthetic firm data;
- Expected health spending by firm;
- Insurer rating practices;
- Age and Gender Adjustment;
- Industry and group size adjustments; and
- Loss ratio adjustments.

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1. Synthetic Firms

To simulate the impact of reform on employers, we develop a "synthetic" database of firms that, includes detailed health status and spending information for each worker and dependent in the firm, in addition to other firm characteristics information. We begin with a database of employers based upon data from the Kaiser Family Foundation survey of employer in 2006, which includes health plan characteristics data. We then statistically match these data to the Robert Wood Johnson Foundation (RWJF) survey of employers, which provides detailed information on the distribution of workers within each firm by earnings level, age, gender and other worker characteristic.

We enhance these data to include detailed information on health spending, income and family characteristics. The first step was to statistically match each MEPS worker, which we call the "primary worker", with one of the employer health plans in the 2006 KFF/RWJF data. We then populate that firm by randomly assigning other workers drawn from the MEPS file with characteristics similar to those reported for the KFF/RWJF database. For example, a firm assigned to a given MEPS worker that has 5 employees would be populated by that worker plus another four MEPS workers chosen at random who also fit the employer's worker profile.

This process is repeated for each worker in the HBSM data to produce one unique synthetic firm for each MEPS worker (about 63,000 synthetic firms). Synthetic firms are created for all workers including those who do not sponsor health insurance, and workers who do not take the coverage offered through work.

2 Expected Health Spending by Firm

As discussed above, insurers often take health status into account in setting small group premiums. In states where permitted, rating is affected by historical claims experience and other health status information. To simulate the rate setting process, we develop a process for estimating expected health care costs for each firm at the beginning of each rating year, which we assume is used as the basis of all health status related decisions. We do this by calculating health spending for workers in each firm for each of two consecutive years using data provided for working families in the MEPS.

As discussed above, the MEPS include detailed health spending data for two consecutive years for each individual, which is included for each worker assigned to each firm. Thus, we are able to tabulate average spending for workers in each firm in the second year by percentile ranking of average employee spending in the prior year as shown in ***Figure B-8***.

In this simulation, we assume that the insurer is estimating this expected spending level for each firm at the end of the first year to use in setting premiums for the coming year. We do this by assigning to each firm an expected spending level for the second year using the data shown in ***Figure B-8***. This expected value is used to set premiums at the beginning of the second year.

Naturally for each firm, actual spending in the second year (which we term the simulation year) will differ from the predicted average expected spending amounts depending upon the expenses actually experienced by workers in the second year. This reflects that while insurers cannot know actual spending for each group in advance, they can use medical information to predict spending levels that will on average track with actual spending during the rating year.

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Figure B-8
Average Costs Per Person in Two Consecutive Years for Synthetic Firms Groups by Percentile Ranking of First Year Group Costs by Firm Size in 2010

Percentile of Year 1 Costs	Average Costs Per Covered Individual									
	Under 10		10-24		25-99		100-199		1,000-5,000	
	Year 1 Costs	Year 2 Costs	Year 1 Costs	Year 2 Costs	Year 1 Costs	Year 2 Costs	Year 1 Costs	Year 2 Costs	Year 1 Costs	Year 2 Costs
10 Percent	$142	$1,132	$684	$1,578	$1,250	$1,912	$2,003	$2,406	$2,547	$2,598
20 Percent	$397	$1,633	$1,114	$1,885	$1,688	$2,250	$2,390	$2,675	$2,752	$2,815
30 Percent	$658	$1,759	$1,443	$2,123	$1,981	$2,453	$2,616	$2,818	$2,870	$2,911
40 Percent	$961	$1,885	$1,755	$2,325	$2,245	$2,608	$2,799	$2,950	$2,968	$2,987
50 Percent	$1,372	$2,311	$2,093	$2,551	$2,510	$2,752	$2,970	$3,068	$3,068	$3,078
60 Percent	$1,960	$2,730	$2,476	$2,756	$2,795	$2,936	$3,141	$3,180	$3,172	$3,194
70 Percent	$2,646	$2,744	$2,932	$3,021	$3,129	$3,058	$3,331	$3,298	$3,290	$3,294
80 Percent	$3,402	$3,398	$3,571	$3,381	$3,571	$3,296	$3,569	$3,404	$3,434	$3,412
90 Percent	$5,631	$5,446	$4,703	$3,793	$4,236	$3,599	$3,919	$3,585	$3,638	$3,538
95 Percent	$7,897	$5,619	$6,392	$4,631	$5,189	$4,004	$4,403	$3,835	$3,917	$3,784
97.5 Percent	$13,123	$8,300	$8,396	$5,376	$6,201	$4,428	$4,925	$4,200	$4,220	$4,029
98.75 Pct	$20,262	$11,294	$10,849	$5,810	$7,357	$4,672	$5,452	$4,485	$4,599	$4,548
100 Percent	$40,825	$19,210	$16,406	$7,280	$9,823	$5,332	$6,421	$4,713	$5,262	$4,931
Total	$3,467	$3,467	$2,852	$2,852	$2,913	$2,913	$3,153	$3,153	$3,151	$3,151

Source: The Lewin Group estimates using HBSM Synthetic firm data.

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3. *Insurer Rating Practices*

The methods used by insurers to rate small group insurance vary with state regulations and insurer policy. ***Figure B-9*** presents a summary of the small group rating rules that apply in each state supplied by the National Association of Health Underwriters (NAHU). In some states, insurers are not allowed to vary premiums with health status, but are allowed to vary premiums by age subject to rating bands. New York, for example, has a community rated system, which means that insurers are required to charge a single premium for each product for all small groups purchasing coverage in the state by geographic area.

Figure B-9: State Rating Limits for Small Group Markets

St No.	State Name	Group Size		Rating Limits
		Min	Max	
1	Alabama	2	50	4: +/- 20-25% rating bands
2	Alaska	2	50	3: +/- 30-35% rating bands
3	Arizona	2	50	2: +/- 50% rating bands
4	Arkansas	2	50	4: +/- 20-25% rating bands
5	California	2	50	4: +/- 20-25% rating bands
6	Colorado	1	50	5: ACR: adjusted community rating
7	Connecticut	1	50	5: ACR: adjusted community rating
8	Delaware	1	50	3: +/- 30-35% rating bands
9	Dist of Columbia	2	50	1: NRS: no rating structure
10	Florida	1	50	4: +/- 20-25% rating bands
11	Georgia	2	50	4: +/- 20-25% rating bands
12	Hawaii	1	50	3: +/- 30-35% rating bands
13	Idaho	2	50	2: +/- 50% rating bands
14	Illinois	2	50	4: +/- 20-25% rating bands
15	Indiana	2	50	3: +/- 30-35% rating bands
16	Iowa	2	50	4: +/- 20-25% rating bands
17	Kansas	2	50	4: +/- 20-25% rating bands
18	Kentucky	2	50	3: +/- 30-35% rating bands
19	Louisiana	2	35	3: +/- 30-35% rating bands
20	Maine	1	50	4: +/- 20-25% rating bands
21	Maryland	2	50	3: +/- 30-35% rating bands
22	Massachusetts	1	50	5: ACR: adjusted community rating
23	Michigan	2	50	2: +/- 50% rating bands
24	Minnesota	2	50	4: +/- 20-25% rating bands
25	Mississippi	1	50	4: +/- 20-25% rating bands
26	Missouri	2	25	4: +/- 20-25% rating bands
27	Montana	2	50	4: +/- 20-25% rating bands
28	Nebraska	2	50	4: +/- 20-25% rating bands
29	Nevada	2	50	4: +/- 20-25% rating bands

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St No.	State Name	Group Size		Rating Limits
		Min	Max	
30	New Hampshire	1	50	4: +/- 20-25% rating bands
31	New Jersey	2	50	5: ACR: adjusted community rating
32	New Mexico	2	50	4: +/- 20-25% rating bands
33	New York	2	50	6: C: pure community rating
34	North Carolina	1	50	4: +/- 20-25% rating bands
35	North Dakota	2	25	3: +/- 30-35% rating bands
36	Ohio	2	50	3: +/- 30-35% rating bands
37	Oklahoma	2	50	4: +/- 20-25% rating bands
38	Oregon	2	50	5: ACR: adjusted community rating
39	Pennsylvania	2	50	1: NRS: no rating structure
40	Rhode Island	1	50	3: +/- 30-35% rating bands
41	South Carolina	2	50	4: +/- 20-25% rating bands
42	South Dakota	2	50	4: +/- 20-25% rating bands
43	Tennessee	2	25	3: +/- 30-35% rating bands
44	Texas	2	50	4: +/- 20-25% rating bands
45	Utah	2	50	3: +/- 30-35% rating bands
46	Vermont	1	50	5: ACR: adjusted community rating
47	Virginia	2	50	4: +/- 20-25% rating bands
48	Washington	2	50	5: ACR: adjusted community rating
49	West Virginia	2	50	3: +/- 30-35% rating bands
50	Wisconsin	2	50	3: +/- 30-35% rating bands
51	Wyoming	2	50	3: +/- 30-35% rating bands

Figure B-10 summarizes the rating factors we assume are used for states with various types of rating restrictions. While many states limit premium variation with rating bands, insurers are often permitted to use a variety of other rating factors such as age, industry, group size and health status. Less is known about the use of these rating factors because they are optional to the insurer.

Figure B-10: Rate Tables used for Rating Method Type for Small Groups

		Age Rating	Loss Ratio
1:	no rating structure	based on Figure 11	4:1
2:	+/- 50% rating bands	based on Figure 11	4:1
3:	+/- 30-35% rating bands	based on Figure 11	3:1
4:	+/- 20-25% rating bands	based on Figure 11	3:1
5:	Modified community rating	4:1	None
6:	pure community rating	none	None

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Consequently, we randomly assign the rating structures that will be applied to each firm in the data, subject to state limits on premium variation. Based upon prior studies by the Congressional Research Service and information supplied by actuaries, we assume the prevalence of use for these rating factors is as shown in ***Figure B-11***.

Figure B-11: Rating Factor Distribution Table

	Firm Size		
	Under 10	**10-24**	**25-99**
Age rating	100%	100%	100%
Industry	79%	97%	98%
Group size	80%	64%	80%
Health status	75%	72%	80%

4. Age and Gender Rates

Insurers typically estimate small group premiums based upon a combination of factors applied sequentially to a base premium amount. The first step is to estimate a premium based upon the age and gender of their workers. Here we start with a base rate for each individual worker that is then adjusted to reflect differences in costs by age and sex. We use single year of age by gender and health status - as reflected in the expected loss ratio - in states with minimal rate regulation (***Figure B-12***). For others, we use rating bands that vary from 4:1 to 3:1 adjustments depending upon the degree of rate compressions required in the firm's state of residence (***Figure B-13***). At this point, the firm premium is the sum of the age and sex adjusted premiums for each person in the group.

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Figure B-12: Age Rating Factors Single Year of Age by Gender Premium Adjustment

Age	Individuals		Family	
	Male	Female	Male	Female
17	0.4869	0.6008	0.4016	1.6568
18	0.4469	0.5868	0.5579	1.5048
19	0.4503	0.6320	0.8402	1.2249
20	0.4303	0.8518	1.0727	0.8905
21	0.4403	0.9057	1.0727	0.7201
22	0.4503	0.9640	1.1487	0.6747
23	0.4476	0.9989	1.0530	0.7020
24	0.4576	1.0664	0.9027	0.7068
25	0.4662	1.3368	0.8242	0.7227
26	0.4762	1.2984	0.8106	0.7676
27	0.5000	1.2995	0.8773	0.7805
28	0.5120	1.2711	0.9247	0.7490
29	0.5243	1.2457	0.9284	0.7200
30	0.5368	1.2937	0.8832	0.8285
31	0.5497	1.3247	0.8832	0.8285
32	0.5629	1.3564	0.8881	0.8530
33	0.5815	1.4013	0.9053	0.8271
34	0.6007	1.4475	0.9153	0.7442
35	0.6225	1.1780	0.9838	0.6967
36	0.6423	1.2155	1.0953	0.6761
37	0.6622	1.2531	1.2067	0.6761
38	0.6887	1.3033	1.2071	0.6868
39	0.7152	1.3534	1.1226	0.7012
40	0.7450	1.2852	1.0025	0.7448
41	0.7748	1.2556	0.9341	0.7900
42	0.8046	1.2260	0.9069	0.8208
43	0.8377	1.2015	0.9033	0.8508
44	0.8741	1.1820	0.9119	0.8656
45	0.9105	1.1092	0.9021	0.8906
46	0.9503	1.1423	0.9208	0.8464
47	0.9900	1.1754	0.9533	0.7726
48	1.0430	1.2085	1.0383	0.6960
49	1.0960	1.2416	1.0771	0.6681
50	1.1522	1.2747	1.0888	0.6642
51	1.2152	1.3112	1.1270	0.6298
52	1.2781	1.3476	1.2501	0.6008
53	1.3476	1.3973	1.4569	0.6252
54	1.4204	1.4469	1.5695	0.7218
55	1.4966	1.4966	1.6303	0.8404
56	1.5794	1.5496	1.5560	0.9069
57	1.6621	1.6059	1.5217	0.9273
58	1.7548	1.6688	1.4037	0.9276
59	1.8542	1.7350	1.3323	0.9605
60	1.9568	1.8045	1.2751	1.1107
61	2.0661	1.8740	1.3481	1.4748
62	2.1820	1.9502	1.5066	2.1395
63	2.2945	2.0197	1.7577	2.9443
64	2.4137	2.0926	2.1359	3.6889
65	2.8144	2.3277	2.6246	4.2686

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Figure B-13
Rating factors by age in states with Rating Bands

Age Adjustment: 4:1 Rate Band		
< 20	0.5737	1.0426
20-24	0.6646	0.8932
25-29	0.6712	0.8165
30-34	0.8899	0.8566
35-39	0.8856	0.9603
40-44	1.2239	0.8895
45-49	1.5479	0.9085
50-54	1.4842	1.0865
55-59	1.4457	1.3230
60+	2.2627	2.0021
Age Adjustment 3:1 Rate Band		
< 25	0.6355	0.9190
25-34	0.7517	0.8407
35-44	1.0635	0.9234
45-54	1.5191	0.9704
55+	1.9144	1.5726

In states with little or no regulation of rates, we assume that insurers use single year of age. In states with rating bands of +/- 50 percent, we assume rates vary with age on a 4:1 basis. The age rate band is assumed to be 3:1 in states with 30 percent to 50 percent rating bands and 3:1 in states with rating bands of less than 30 percent. We assume 4:1 rate variation by age in states with adjusted community rating, which does not permit rates to vary with health status and other factors.

5. Industry and Group Size Adjustment

We also adjust for major industry groups in setting premiums. As discussed above, we use a probability table to determine whether the insurer adjusts for industry in rating groups. ***Figure B-14*** presents two sets of rate adjustment factors by industry. The first is an adjustment for premiums that assumes the group has not been rated by age or any other factor.

The second is a factor that applies to cases where the first stage premium calculation is based on age and gender. This is a conditional adjustment that is designed to capture premium variation by industry that is not already explained by adjusting for age and gender. We estimate both of these adjustments using the MEPS data for people with employer health insurance.

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Figure B-14: Rate Variation by Industry

	Individual		Family	
	Industry not Adjusted	Age/Sex Adjusted	Industry not Adjusted	Age/Sex Adjusted
Agriculture	1.0925	1.1795	0.9339	0.9587
Mining	1.1069	1.1845	1.0010	0.9962
Construction	1.2331	1.3397	0.9626	0.9681
Manufacturing	1.1223	1.1838	1.0152	0.9649
Transportation	1.1072	1.1865	1.0469	0.9863
Wholesale Trade	0.4861	0.5710	0.9907	1.0025
Retail Trade	0.5261	0.6023	0.9890	0.9673
Finance	1.1335	1.2115	0.9910	0.9871
Services	0.8731	0.8256	1.0708	1.1256
S&L Gov	1.1679	1.0621	1.0095	1.0585
Individuals	1.0698	1.0452	0.8025	0.7697

In addition, we adjust for group size in cases where the model selects a firm to be rated on the basis of group size, in addition to other factors. The rate adjustments are conditional depending upon the factors used thus far to set the premium. Thus, for example, the group size adjustment is only the factor that explains premium variation beyond what has already been captured with a prior stage adjustment such as age or industry. *Figure B-15* presents the adjustment factors used depending upon the factors use to adjust the premium to this point in the calculation.

6. Loss Ratio Adjustments

In the final step, we perform a health status adjustment based upon a loss ratio calculated in the model for each firms in states where health status rating is permitted. We estimate these factors by using the rating factors described above to calculate a premium for each group. We then divide estimated average expected costs for the group over the adjusted premium. The result is an adjuster that accounts for the variation in expected health care costs that is not explained by the other rating factors described above.

We estimate these adjusters conditioned on the use of other rating factors in setting the premium up to this point. We assume that the loss ratio adjustment varies from 4:1 to 3:1 depending upon the allowable rate band in their state of residence. These adjusters are shown in ***Figure B-16***.

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Figure B-15: Rate Variation by Group Size

	Individual				Family			
	Group Size Adjusted Only	Age/Sex Adjusted Only	Age/Sex Industry Adjusted	Industry Adjusted Only	Group Size Adjusted Only	Age/Sex Adjusted Only	Age/Sex Industry Adjusted	Industry Adjusted Only
2-9	0.9751	0.9413	1.0076	1.0651	0.9558	0.9621	0.9312	0.9339
10-24	0.9172	0.9344	0.9813	1.0079	0.9840	1.0201	0.9977	0.9658
25-99	0.8996	0.9436	0.9800	0.9674	0.9823	1.0296	1.0084	0.9626
100-499	0.9318	0.9095	0.9856	0.9999	1.0555	1.0282	1.0025	1.0314
500-999	0.9906	1.0015	1.0031	0.9989	1.0464	1.0408	1.0189	1.0247
1000-4999	1.0503	1.0484	1.0174	0.9980	1.0397	1.0255	0.9976	1.0215

Figure B-16: Health Status Adjustment Based on Expected Loss Ratio

	No Age & Sex Adjustment				Age/Sex Adjustment			
	Unadjusted	Group	Industry	Group Size and Industry	Unadjusted	Group	Industry	Group Size and Industry
Loss Ratio 4:1 Rate Band								
0-50	0.4513	0.4635	0.4705	0.4734	0.4944	0.5137	0.5126	0.5151
50-75	0.8500	0.8523	0.8623	0.8655	0.8730	0.8645	0.8858	0.8753
75-100	0.9851	0.9785	0.9804	0.9835	0.9874	0.9879	1.0010	1.0054
100-125	1.1063	1.0818	1.0974	1.0816	1.0967	1.0719	1.0657	1.0591
125-150	1.2121	1.1993	1.1882	1.1868	1.1829	1.1768	1.1634	1.1659
150+	1.9832	2.0597	1.9976	2.0280	1.8891	1.9320	1.9125	1.9144
Loss Ratio 3:1 Rate Band								
0-75	0.6135	0.6333	0.6353	0.6400	0.6447	0.6631	0.6654	0.6666
75-100	0.9851	0.9785	0.9804	0.9835	0.9874	0.9879	1.0010	1.0054
100-125	1.1063	1.0818	1.0974	1.0816	1.0967	1.0719	1.0657	1.0591
125+	1.6204	1.6736	1.6343	1.6582	1.5543	1.5925	1.5737	1.5838

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C. Simulating Enrollment in High-Risk Pools

To determine the number of people that will be enrolled in high-risk pools prior to the implementation of the ACA, we compile the number of members and monthly allowed costs per member in existing state high-risk pools for 2013 (***Figure B-17***). We also estimate the number of members and average monthly allowed costs for people that we anticipate will be enrolled in the temporary federal high risk-pools for each state in 2013. We trend the allowed cost number to 2014 (our simulation year) by six percent to account for health care inflation.

Neither the Current Population Survey (CPS) nor the Medical Expenditure Panel Survey (MEPS), which are the primary data sources for HBSM, provides information on people enrolled in high-risk pools. Therefore, we need to impute high-risk pool coverage in HBSM. To do this, we select a subset of people with non-group coverage that also had a health condition that is typically used to determine eligibility for existing state high-risk pools.

We randomly select people that met the above criteria in each state in the HBSM data so to match the total number of people we project to be enrolled in either the current state high-risk pools or the temporary federal high-risk pools. We then adjust the average monthly spending for these people in HBSM to match our estimates for each state. We then adjusted the average covered costs for people remaining in the non-group market so to match the NAIC data, which we have assumed does not include high-risk pool enrollees.

This imputation method may potentially overstate our baseline cost estimates for uninsured people. Our coverage estimates are based on data prior to the implementation of the federal high-risk pools, where enrollees in this program would be categorized as uninsured. Thus, some of the higher cost uninsured in the data would now be covered through the high risk pool, which would reduce the overall average cost for those remaining uninsured. However, we do not believe that this makes a material difference in the estimate do to the fact that only about 164,000 of the 52.4 million uninsured are assumed to be enrolled in the Federal high risk pool. However, the reader can make a determination for a particular state based on the information presented.

Figure B-17: Estimated High-Risk Pool Enrollment and Allowed Cost in 2013

	Current State High-Risk Pools		Temporary Federal High-Risk Pools		Combined State and Federal High-Risk Pools	
State	Members	Allowed Cost PMPM	Members	Allowed Cost PMPM	Members	Allowed Cost PMPM
ALABAMA	2,050	$1,158	1,300	$3,824	3,350	$2,193
ALASKA	526	$2,576	46	$13,885	572	$3,485
ARIZONA	0	$0	8,453	$2,713	8,453	$2,713
ARKANSAS	2,696	$992	1,381	$1,548	4,077	$1,181
CALIFORNIA	6,051	$1,052	26,790	$3,921	32,841	$3,393
COLORADO	13,775	$1,165	1,907	$3,345	15,682	$1,430
CONNECTICUT	1,492	$1,801	1,133	$1,821	2,625	$1,810
DELAWARE	0	$0	472	$1,432	472	$1,432
DC	0	$0	100	$1,680	100	$1,680

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State	Current State High-Risk Pools		Temporary Federal High-Risk Pools		Combined State and Federal High-Risk Pools	
	Members	Allowed Cost PMPM	Members	Allowed Cost PMPM	Members	Allowed Cost PMPM
FLORIDA	202	$1,262	18,322	$2,690	18,524	$2,674
GEORGIA	0	$0	5,056	$2,778	5,056	$2,778
HAWAII	0	$0	246	$3,171	246	$3,171
IDAHO	1,794	$851	1,821	$7,052	3,615	$3,975
ILLINOIS	20,445	$1,271	4,412	$2,013	24,857	$1,403
INDIANA	7,364	$1,981	3,389	$2,673	10,753	$2,199
IOWA	3,234	$1,375	478	$2,604	3,712	$1,534
KANSAS	1,476	$1,860	735	$3,829	2,211	$2,514
KENTUCKY	4,430	$1,494	2,233	$1,867	6,663	$1,619
LOUISIANA	1,738	$1,330	2,521	$2,091	4,259	$1,781
MAINE	0	$0	69	$5,399	69	$5,399
MARYLAND	20,238	$1,040	1,634	$2,186	21,872	$1,126
MASSACHUSETTS	0	$0	49	$4,054	49	$4,054
MICHIGAN	0	$0	4,036	$3,927	4,036	$3,927
MINNESOTA	26,476	$1,207	1,344	$2,103	27,820	$1,250
MISSISSIPPI	3,299	$1,137	680	$3,763	3,979	$1,586
MISSOURI	3,986	$1,412	3,285	$3,291	7,271	$2,261
MONTANA	2,775	$1,154	428	$2,624	3,203	$1,351
NEBRASKA	3,824	$1,531	809	$3,905	4,633	$1,945
NEVADA	0	$0	2,363	$3,451	2,363	$3,451
NEW HAMPSHIRE	2,751	$1,121	1,149	$6,150	3,900	$2,603
NEW JERSEY	0	$0	1,638	$3,491	1,638	$3,491
NEW MEXICO	8,442	$1,509	2,076	$2,860	10,518	$1,776
NEW YORK	0	$0	6,645	$3,012	6,645	$3,012
NORTH CAROLINA	9,280	$896	8,459	$759	17,739	$831
NORTH DAKOTA	1,443	$950	185	$4,581	1,628	$1,364
OHIO	0	$0	4,453	$1,968	4,453	$1,968
OKLAHOMA	2,515	$1,735	1,316	$3,366	3,831	$2,295
OREGON	11,761	$1,313	2,324	$3,647	14,085	$1,698
PENNSYVANIA	0	$0	8,545	$1,287	8,545	$1,287
RHODE ISLAND	0	$0	204	$2,981	204	$2,981
SOUTH CAROLINA	1,739	$1,426	2,903	$2,650	4,642	$2,192
SOUTH DAKOTA	610	$1,283	271	$7,623	881	$3,233
TENNESSEE	3,132	$1,376	2,919	$2,823	6,051	$2,074
TEXAS	24,174	$1,454	14,848	$4,856	39,022	$2,749
UTAH	3,666	$1,013	1,808	$3,530	5,474	$1,844
VERMONT	0	$0	0	$0	-	$0
VIRGINIA	0	$0	4,626	$2,440	4,626	$2,440
WASHINGTON	3,706	$2,420	1,156	$4,613	4,862	$2,941
WEST VIRGINIA	1,173	$842	340	$2,498	1,513	$1,214
WISCONSIN	21,645	$1,114	3,043	$1,043	24,688	$1,105
WYOMING	1,001	$1,310	506	$1,844	1,507	$1,490

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D. Simulating Non-Group Premiums under the ACA

The model simulates premiums for people in the individual market under the ACA using rating restrictions specified in the Act. The ACA allows rating variation based only on age (limited to 3:1), geography, family composition and tobacco use (limited to 1.5:1). Similar to the steps described above for calculating individual market premiums, the HBSM model uses a premium equal to the base rate for single and family coverage which is adjusted for age, single/family coverage and state. The model does not include data on tobacco use, so we do not adjust for tobacco use. Gender, health status and expected loss ratios are not used in that ACA premium calculation.

The age adjustments are estimated from the MEPS data for privately insured people. These adjustments are performed separately for individual policy holders and family policy holders. The model uses a base rate for individuals and a base rate for family coverage, both of which vary with the age of the policyholder only. ***Figure B-18*** shows the age adjustments used for the 3:1 rating limits.

Figure B-18: Age Rating Factors in the Individual Market under the ACA

	Individual	Family
Age Adjustment Limited to 3:1 Rate Band		
< 25	0.6355	0.9190
25-34	0.7517	0.8407
35-44	1.0635	0.9234
45-54	1.5191	0.9704
55+	1.9144	1.5726

CMS recently released its proposed standard age curve by single year of age, which is different from the method used for this analysis. However, we do not believe this difference will make a material difference because premium subsidies have a much larger impact on the cost of insurance to individuals in our simulation as compared to premium rating practices. Using age bands will, as we have done in this analysis, has the effect of compressing premium variation for all ages within the age band. Premiums based on single year of age will result in more variation across all ages. For states that currently do not have rating restrictions, which we assume use single year of age rating plus health status rating, that will move to a 3:1 rating limit using age bands could produce a greater difference in premiums (current compared to ACA) for certain ages as compared to premiums using a single year of age curve as proposed by CMS. Since this analysis uses an elasticity model to simulate participation that is based on a change in price, then these premium differences could have an effect on who participates.

However, we estimate that most people purchasing coverage in the individual market under the ACA will receive premium subsidies, which effectively reduces premium costs. We found that premium subsidies have the largest impact on change in price of insurance and thus the largest impact on participation. Because premium subsidies have such an impact on the cost of insurance to individuals in our simulation, premium calculations using a single year of age

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curve versus an age band curve does not make a material difference for simulating non-group participation under the ACA.

E. Simulating Small Group Premiums under the ACA

The model simulates premiums for fully insured small groups (100 or fewer members) under the ACA using rating restrictions specified in the Act. Similar to the individual market, the ACA allows rating variation based only on age (limited to 3:1), geography, family composition and tobacco use (limited to 1.5:1) in the small group market. Similar to the steps described above for calculating small group premiums under current law, HBSM estimates a premium based only upon the age workers in the group. Here, we start with a base rate for each individual worker that is then adjusted to reflect differences in costs by age. As specified under the ACA, we restrict rating variation to 3:1 ratio based on the adjustments shown in ***Figure B-18***. At this point, the firm premium is the sum of the age and sex adjusted premiums for each person in the group. The model does not include data on tobacco use, so we do not adjust for tobacco use. Health status and expected loss ratios are not used in that ACA premium calculation nor are new taxes and fees.

For modeling purposes, we assume that premiums for self-insured firms and large groups are unaffected under the ACA.

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Appendix C – State Specific Excel Spreadsheets

The Excel spreadsheets can be found on the web page that is housing this report on the SOA web site.

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March 2013

Issue Brief

Insurers' Medical Loss Ratios and Quality Improvement Spending in 2011

Mark A. Hall and Michael J. McCue

ABSTRACT: The Affordable Care Act's medical loss ratio (MLR) regulation requires insurers to spend 80 percent or 85 percent of premiums on medical claims and quality improvements. In 2011, insurers falling below this minimum paid more than $1 billion in rebates. This brief examines how insurers spend their premium dollars—particularly their investment in quality improvement activities—focusing on differences among insurers based on corporate traits. In the aggregate, insurers paid less than 1 percent of premiums on either MLR rebates or quality improvement activities in 2011, with amounts varying by insurer type. Publicly traded insurers had significantly lower MLRs in each market segment (individual, small group, and large group), and were more likely to owe a rebate in most segments compared with non–publicly traded insurers. The median quality improvement expenditure per member among nonprofit and provider-sponsored insurers was more than the median among for-profit and non-provider-sponsored insurers.

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OVERVIEW

The Patient Protection and Affordable Care Act requires health insurers generally to pay out at least 80 percent or 85 percent of premiums for medical claims and quality improvement expenses.[1] Insurers that pay out less than this minimum—known as a medical loss ratio, or MLR—must refund the difference to their policyholders. In 2012, 14 percent of all health insurers paid more than $1 billion in rebates to consumers, based on their 2011 MLRs.[2] In addition to refunding premium fees to consumers, the new MLR rule prompted insurers to reduce their administrative costs and profit margins by about $1 billion across all three market segments—large-group, small-group, and individual insurance—compared with 2010.[3]

The MLR rule also requires insurers to report their spending on four quality improvement activities, defined as activities that are likely to improve health outcomes, prevent hospital readmissions, improve patient safety and reduce

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medical errors, and increase wellness and health promotion. They also must report the amount they spend on health information technology related to health improvement. These expenditure reports do not, however, measure actual quality of care or health outcomes.

This issue brief examines how MLRs, rebates, and quality improvement expenses differed by health insurers' corporate characteristics. We include all 947 insurers that were subject to the MLR regulation in 2011. These are the so-called credible insurers, meaning those with 1,000 or more members in a state's individual, small-group, or large-group market segment.[4] (See Data Collection and Methodology.)

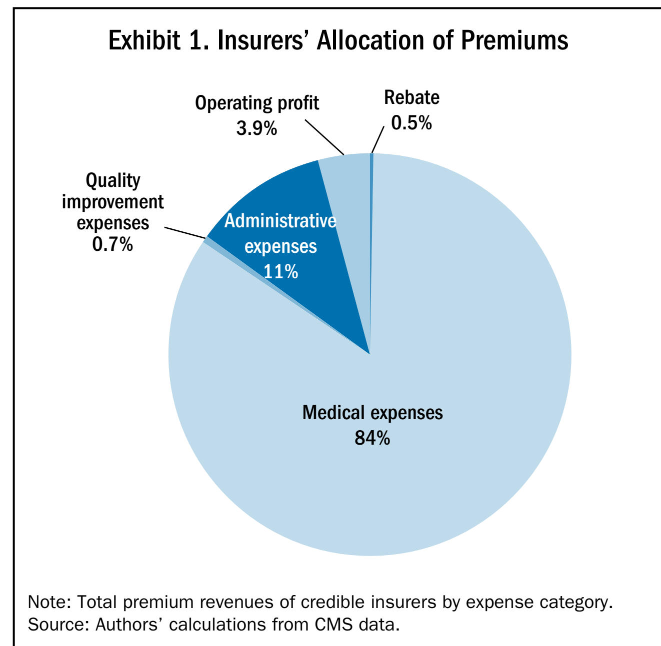
On average and at the median, insurers allocated less than 1 percent of premium dollars to activities designed to improve health outcomes, prevent hospital readmissions, improve patient safety, increase wellness, or enhance the use of health care data to improve quality.[5] Separately, insurers also report, on the medical loss ratio reporting forms, the size of incentives they pay to health care providers to reduce costs and promote quality improvement.[6] In 2011, this total amounted to an additional 0.35 percent of premium revenues. While these incentive programs are important and are expected to grow over time, our analysis focuses solely on direct quality improvement expenses reported by insurers in 2011, which are linked to identifiable quality improvement activities.

The amounts spent on quality improvement varied considerably by corporate traits.[7] The median nonprofit and provider-sponsored plans spent more on quality improvement than their counterparts—for-profit and non-provider-sponsored plans. Similarly, only a small percentage (less than 10 percent) of nonprofits and provider-sponsored insurers paid an MLR rebate, whereas more than 20 percent of for-profit and non-provider-sponsored insurers paid a rebate because they fell below the minimum MLRs.

MLR AND REBATE FINDINGS

Overall, credible health insurers devoted 84 percent of premium revenues to medical expenses, 11 percent to administrative overhead, 0.7 percent to quality improvement activities, and 0.5 percent to premium rebates.[8] Insurers retained the remaining 3.9 percent of premium revenues as operating surplus (i.e., pretax profits) (Exhibit 1).

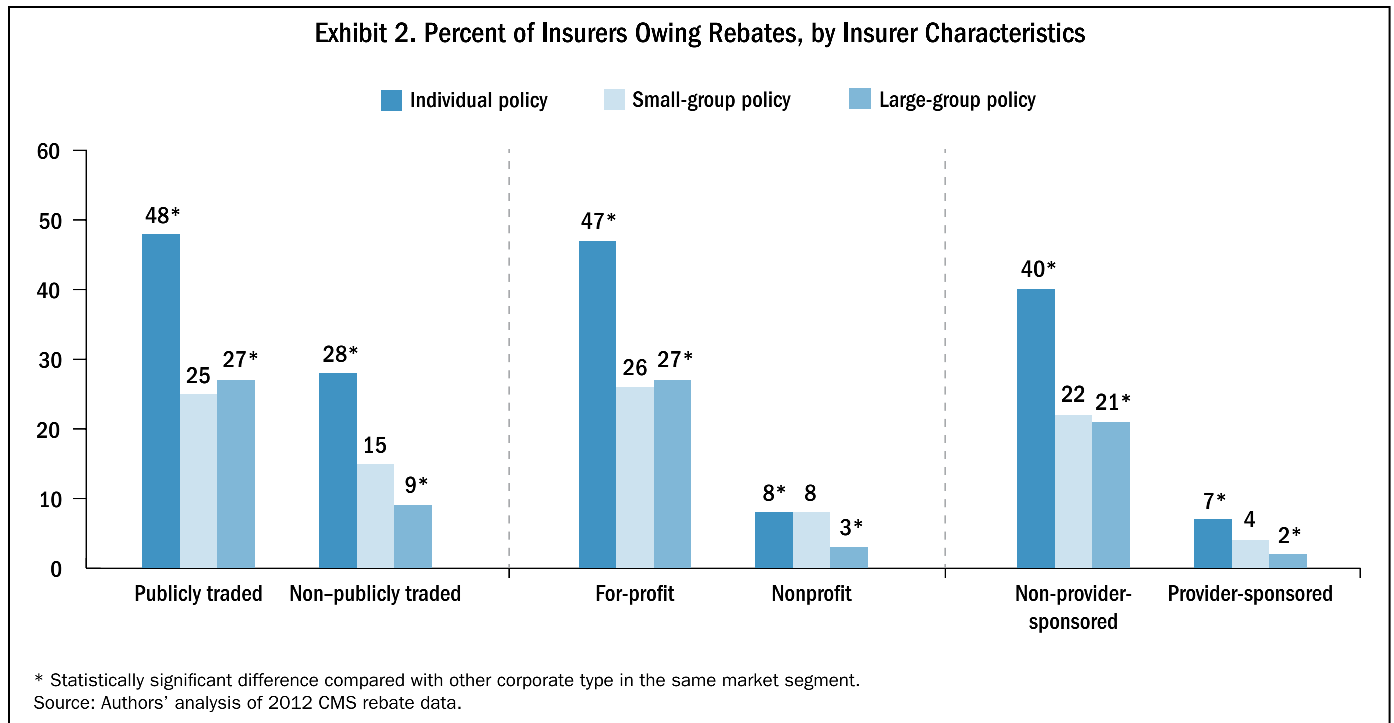
Exhibit 1. Insurers' Allocation of Premiums



Note: Total premium revenues of credible insurers by expense category.
Source: Authors' calculations from CMS data.

Exhibit 2 presents the percent of insurers owing rebates, and Exhibit 3 provides more detail on the amount of rebates and the simple and adjusted MLRs, by individual, small-group, and large-group policies. The adjusted MLR number, which is the basis for calculating rebates owed, includes additional factors that reflect the insurer's size and whether it offers high-deductible plans.[9] Within the individual market, substantially more of the publicly traded insurers (48%) owed a rebate, compared with 28 percent of the non–publicly traded insurers (Exhibit 2). (It is important to note that nonpublic insurers include both nonprofits and private for-profits.) However on a per-member basis, the median publicly traded insurer that owed a rebate in the individual market owed a lower amount than the median non–publicly traded insurer that owed a rebate ($94 vs. $174) (Exhibit 3). Also, for all credible insurers, regardless of whether they owed a rebate, both the simple and adjusted median MLRs were significantly lower for the publicly traded insurers.

Exhibit 2. Percent of Insurers Owing Rebates, by Insurer Characteristics



* Statistically significant difference compared with other corporate type in the same market segment.
Source: Authors' analysis of 2012 CMS rebate data.

Exhibit 3. Rebate and Medical Loss Ratio Analysis by Insurer Traits

Individual Policy	Median rebate per member (among insurers owing any rebate)		Median simple MLR (all credible insurers)		Median adjusted MLR (all credible insurers)	
Publicly traded (n=260)	$94	*	75%	*	80%	*
Non–publicly traded (n=269)	$174		82%		86%	
For-profit (n=400)	$122	**	75%	*	80%	*
Nonprofit (n=129)	$34		90%		92%	
Non-provider-sponsored (n=488)	$123	ns	78%	*	82%	*
Provider-sponsored (n=41)	$23		94%		98%	
Small-Group Policy						
Publicly traded (n=268)	$111	ns	81%	*	83%	*
Non–publicly traded (n=291)	$119		84%		87%	
For-profit (n=370)	$119	ns	81%	*	83%	*
Nonprofit (n=189)	$88		86%		88%	
Non-provider-sponsored (n=481)	$117	ns	82%	*	84%	*
Provider-sponsored (n=78)	$72		88%		90%	
Large-Group Policy						
Publicly traded (n=300)	$90	ns	85%	*	88%	*
Non–publicly traded (n=281)	$144		90%		91%	
For-profit (n=368)	$99	ns	85%	*	88%	*
Nonprofit (n=213)	$91		90%		91%	
Non-provider-sponsored (n=492)	$99	ns	87%	*	89%	*
Provider-sponsored (n=89)	$176		91%		93%	

Notes: Simple MLR = medical claims and quality improvement expenses divided by premiums earned less taxes and regulatory fees. Adjusted MLR increases the simple medical loss ratio on a sliding scale for plans with smaller enrollment or high deductibles (see note 7).
** = significant at .05 level; * = significant at .01 level; ns = not statistically significant.
Source: Authors' calculations from CMS data.

Publicly traded insurers appear to aim their pricing closer to the minimum loss ratio than do other insurers, whose average MLRs are higher. This is evident in two ways. First, their adjusted MLR marketwide is virtually identical to the 80 percent limit (Exhibit 3). Second, there is a nearly equal split in the number of publicly traded insurers above and below the limit.

Only 8 percent of nonprofit insurers owed a rebate in the individual market compared with 47 percent of for-profit insurers (Exhibit 2). The median nonprofit insurer also paid significantly lower rebates per member ($34 vs. $122) than did the median for-profit carrier in the individual market (Exhibit 3). The median individual market MLRs (both simple and adjusted) were 12 to 15 percentage points higher among nonprofit insurers than among for-profit insurers.

Similar differences were seen between provider-sponsored and non-provider-sponsored insurers, but not all differences were statistically significant. However, the 16-percentage-point differences in both simple and adjusted median MLRs between provider-sponsored and non-provider-sponsored insurers did result in a statistically significant difference in the individual market (Exhibit 3).

Within the small- and large-group markets, corporate traits were associated with MLRs and rebates in ways similar to those seen in the individual market, but with a smaller magnitude of difference (Exhibit 2). Also, publicly traded, for-profit, and non-provider-sponsored plans in the group markets had lower median MLRs than their counterparts (Exhibit 3). Differences in the rebates paid per member were mostly in the same direction as those in the individual market, namely, lower rebates by publicly-traded insurers and higher rebates by for-profit insurers, but the rebate differences in the group market were not statistically significant.

QUALITY IMPROVEMENT FINDINGS

As noted previously, the federal MLR rule counts as medical expenses the amounts that insurers devote to quality improvement and related health information technology (HIT). Federal regulations and guidance specify a range of quality improvement activities that are likely to improve health outcomes, prevent hospital readmissions, improve patient safety and reduce medical errors, or increase wellness and health. By allowing insurers to count spending on these activities toward meeting the minimum MLR, the federal rule has generated a valuable new source of data about how insurers invest in quality improvement.

On average, credible insurers that reported any expenses related to quality improvement spent a total of $2.3 billion, or 0.74 percent of premium revenue. Separately, insurers also report (on the medical loss reporting forms) the size of incentives they pay health care providers to reduce costs and promote quality improvement. This total amounted to $1.1 billion in 2011, or an additional 0.35 percent of premium revenues. Our analysis focuses solely on the quality improvement expenses reported by insurers.

Credible insurers spent $29 per subscriber in 2011 on quality improvement activities, with substantial variations in spending. The median insurer incurred quality improvement expenses of $23 per member, while the top quartile of spenders incurred more than $40 in expenses per member. The bottom quartile reported spending less than $12 per member.

Out of the $2.3 billion spent on quality improvement in 2011, insurers reported that 17 percent was devoted to HIT expenses (Exhibit 4). Of the remainder, 51 percent of quality improvement expenses went to improving outcomes, 9 percent to hospital readmissions, 10 percent to patient safety, and 13 percent to wellness activities. However, a substantial number of insurers reported zero expenses in one or more of these areas. Because a good number of insurers report only total quality improvement expenses, rather than breakdowns by type of improvement, our further analyses will focus only on total quality improvement expenses, including HIT.

We examined whether health plans differ in the amount they spend on quality improvement activities based on their corporate characteristics. Rather than focus on overall spending per member, the analysis

Exhibit 4. 2011 Quality Improvement Expenses by Activities and Members

	Total (millions)	Per member	As percent of total quality expense
Premium	$305,466	$3,916.23	
Total quality improvement	$2,265	$29.04	100%
Health information technology	$381	$4.88	17%
Improve outcomes	$1,164	$14.92	51%
Hospital readmissions	$199	$2.55	9%
Patient safety	$229	$2.94	10%
Wellness	$292	$3.74	13%

Source: Authors' calculations from CMS data of all credible insurers reporting any quality improvement expenses.

calculated the median amount spent per member by different types of insurers. Although this approach disregards the fact that some insures are much larger than others (see methodology box on p.8), it is appropriate for studying institutional behavior, since it gives equal weight to each insurer. As shown in Exhibit 5, provider-sponsored insurers made the greatest investment in quality improvement, with a median of $37 per member spent on these activities in 2011. This is 63 percent more per member than the $23 per member spent by non-provider-sponsored insurers.

The differential in quality investment was even greater for nonprofit insurers. Their median expenditure per member on quality improvement was nearly twice the median among for-profit insurers. However, no significant difference was observed in median quality improvement expenses between insurers that were and were not publicly traded (Exhibit 5). One notable difference is that publicly traded insurers spent significantly higher amounts—50 percent more—than nonpublic insurers on the HIT component of quality improvement expenses (analysis not shown).

On average and at the median, insurers spent less than 1 percent of premium dollars in 2011 on activities that meet the federal definition for quality improvement. While some might attribute this level to a narrow definition of allowable quality-related activities, the federal rule appears to be fairly broad. Although it requires that activities "be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional [or government] . . . organizations," the rule requires only that activities be "primarily designed" to produce good results and does not require insurers to show actual outcomes. Also, the rule provides a long list of activities relating to care management and quality reporting, and includes related health information technology expenses.

One potential explanation for insurers' level of investments in quality is the basic dynamic of

Exhibit 5. 2011 Median Quality Improvement Expenses per Member, by Corporate Traits

Publicly traded (n=456)	**Non–publicly traded** (n=399)	
$26.44	$22.49	
Nonprofit (n=211)	**For-profit** (n=644)	
$35.21	$19.11	*
Provider-sponsored (n=86)	**Non-provider-sponsored** (n=769)	
$36.82	$22.74	*

* = significant at the .01 level.
Source: Authors' calculations from CMS data of all credible insurers reporting any quality improvement expenses.

competitive insurance markets. Competing insurers can be expected to focus most on those attributes that the market rewards most strongly. Consumers certainly care about price and covered benefits. Surely, they also care about quality improvement, but if consumers are not presented with useful quality metrics, it is difficult for them to "vote with their feet" to reward insurers that invest more in quality improvement. Alternatively, quality improvement efforts by insurers that take the form of managed care controls might be viewed negatively by consumers as intruding on the doctor–patient relationship.

The difficulty of measuring, reporting, and evaluating quality in terms consumers can understand and use may explain why the level of investment differs by insurer type. In addition, the greater quality spending among provider-sponsored plans might be driven by the emerging payment systems launched by Medicare and commercial insurers that reward providers for meeting quality-of-care benchmarks.

CONCLUSION

On average and at the median, insurers spent less than 1 cent of each premium dollar in 2011 on MLR rebates. However, this small amount varied significantly among insurers, and the variation was associated with certain corporate characteristics. The MLRs of publicly traded insurers were closer than those of other insurers to the minimum regulated thresholds of 80 percent for the individual and small-group markets and 85 percent for the large-group market. Conversely, insurers operating as nonprofits or those affiliated with health care providers were significantly less likely than their corporate counterparts to owe a rebate, owing to their higher medical loss ratios.

Similar patterns can be seen for health insurers' spending on quality improvement. Overall, insurers spend little of their premium dollars on improving quality, but the investments they do make vary substantially by type of insurer. In 2011, the median spending per member that nonprofit insurers reported for various quality improvement activities was 84 percent more than the median reported by for-profits, and the median by provider-sponsored insurers was 63 percent more than by their nonprovider counterparts.

Because this is the first year that such data have been collected, we cannot be certain that they are entirely complete. Moreover, insurers may not have fully responded yet to the new MLR rule's focus on quality improvement expenses. Nevertheless, the overall level of spending on quality improvement suggests that current market forces do not strongly reward insurers' investments in this area. Therefore, more robust reporting of quality measures may be needed. The Affordable Care Act (section 2717) requires health insurers to report to HHS their benefit and provider reimbursement structures that improve quality in various ways.[10] To be most useful, HHS should synthesize and disseminate this information in a fashion that consumers find useful and relevant, in order to stimulate competitive pressures for health plans to improve quality of care.

Notes

1 For 2011, the Secretary of HHS approved applications by seven states to permit lower medical loss ratios, ranging from 65 percent to 75 percent, in the individual market to prevent market destabilization in those states. See M. A. Hall and M. J. McCue, *Estimating the Impact of the Medical Loss Ratio Rule: A State-by-State Analysis* (New York: The Commonwealth Fund, April 2012). The report of rebates paid take into account these and other permitted adjustments.

2 "Medical Loss Ratio List of Health Insurers Owing Rebates in 2012," http://cciio.cms.gov/resources/files/mlr-issuer-rebates-20120710.pdf; Centers for Medicare and Medicaid Services, "The 80/20 Rule: Providing Value and Rebates to Millions of Consumer," 2012, http://www.healthcare.gov/law/resources/reports/mlr-rebates06212012a.html; and Kaiser Family Foundation, *Insurer Rebates Under the Medical Loss Ratio: 2012 Estimates* (Washington, D.C.: Henry J. Kaiser Family Foundation, April 2012), http://www.kff.org/healthreform/upload/8305.pdf.

3 M. J. McCue and M. Hall, "Impact of Medical Loss Regulation on the Financial Performance of Health Plans," under review at *Health Affairs,* Dec. 2012; and M. J. McCue and M. Hall, *Insurers' Responses to Regulation of Medical Loss Ratios* (New York: The Commonwealth Fund, Dec. 2012).

4 "Credible" refers to the fact that insurers with fewer than 1,000 members in a market segment have less actuarial "credibility," meaning they face greater variability of medical utilization and costs. Therefore, these smallest insurers are presumed to meet the MLR rebate regulation.

5 Total expenditures on quality improvement by all 855 health plans as a share of total premium revenue is 0.74 percent. For total expenditures on quality improvement as a percent of total premiums for each health plan in the sample, the median value is 0.62 percent and mean value is 0.77 percent.

6 The reporting form defines "medical incentive pools and bonuses" as "Arrangements with providers and other risk sharing arrangements whereby the reporting entity agrees to either share savings or make incentive payments to providers to promote quality improvements." See http://www.naic.org/documents/index_health_reform_mlr_blanks_proposal.pdf.

7 Provider-sponsored refers to insurers owned, governed, or managed jointly with health care systems, community health centers, or physician groups.

8 The CMS rebate data available on August 5, 2012, did not explicitly report underwriting gain or loss. Therefore, we calculated operating margins for credible insurers based on reported data about premiums, medical claims, quality improvement expenses, and administrative expenses, but the calculation does not include any investment earnings. The total of 2,441 insurers include those that offered some combination of multiple policies. For example, there were 590 insurers that offered health insurance in all three markets segments.

9 Because carriers with small numbers of enrollees might experience year-to-year volatility in their medical loss ratios because of a few large claims, insurers with fewer than 75,000 members are allowed to decrease their target MLRs on a sliding scale ranging from 8.3 percentage points for 1,000 members to no adjustment for 75,000 or more members. These smaller insurers that also offer a high-deductible plan (greater than $2,500) receive an additional adjustment depending on the deductible size, since high-deductible plans are considered more volatile. For example, having a $10,000 deductible will reduce the target MLR for a 1,000-member carrier by 14.4 percentage points rather than just 8.3 points.

10 E. Hoo, D. Lansky, J. Roski et al., *Health Plan Quality Improvement Strategy Reporting Under the Affordable Care Act: Implementation Considerations* (New York: The Commonwealth Fund, April 2012).

Data Collection and Methodology

Data for this study come from the medical loss ratio (MLR) rebate forms that insurers filed with the Centers for Medicare and Medicaid Services for 2011.[a] Insurers report separately in each state in which they have enrollment, for a total of 2,441 state insurers that offered comprehensive health insurance. However, insurers with enrollment of less than 1,000 have less actuarial "credibility," meaning that they face greater variability of medical utilization and costs; therefore, under federal regulations these smaller insurers are presumed to meet the MLR rebate regulation, and we exclude them from our analysis. There were a total of 947 insurers with 1,000 or more members per state in at least one market segment (individual, small group or large group). Of these, 855 reported quality improvement data. Because the excluded plans are small, they represent only 1 percent of the membership of all reporting insurers for 2011.

Using NAIC data and the AIS Directory of Health Plans, we categorized each insurer according to three corporate traits, noting that an insurer might well have more than one of these traits. Insurers were categorized by the status of their parent company rather than the status of each subsidiary. The median test was used to test differences in median rebate per member as well as medical loss ratio across plans with and without each of these corporate traits. Some results were sensitive to whether quality improvement expenses were measured as averages versus based on the median among each insurer's per-member spending. For instance, for-profit insurers in aggregate reported more spending per member than did nonprofits. That measure, however, weights each insurer's spending according to its size, whereas analysis of median expenditures gives equal weight to each insurer's quality expense per member.

[a] Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight, Submissions of 2011 Medical Loss Ratio Annual Reporting Data (as of August 5, 2012), http://cciio.cms.gov/resources/data/mlr.html. We accessed data from August 5, 2012, filings. We recognized that there may be future updates to the 2011 data; however, since all health insurers were required to file by June 1, 2012, and all rebates were required to be paid by August 1, 2012, we expect further updates will be minimal.

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ANALYSIS & COMMENTARY

Redesigning Primary Care: A Strategic Vision To Improve Value By Organizing Around Patients' Needs

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ABSTRACT Primary care in the United States currently struggles to attract new physicians and to garner investments in infrastructure required to meet patients' needs. We believe that the absence of a robust overall strategy for the entire spectrum of primary care is a fundamental cause of these struggles. To address the absence of an overall strategy and vision for primary care, we offer a framework based on value for patients to sustain and improve primary care practice. First, primary care should be organized around subgroups of patients with similar needs. Second, team-based services should be provided to each patient subgroup over its full care cycle. Third, each patient's outcomes and true costs should be measured by subgroup as a routine part of care. Fourth, payment should be modified to bundle reimbursement for each subgroup and reward value improvement. Finally, primary care patient subgroup teams should be integrated with relevant specialty providers. We believe that redesigning primary care using this framework can improve the ability of primary care to play its essential role in the health care system.

Primary care is widely recognized as essential to any health care system, but the field remains beleaguered.[1] Many primary care practitioners feel frustrated and underappreciated, and fewer than one in ten US medical school graduates enters primary care residency programs.[2] Primary care practices are starved for investment. Meanwhile, patients have difficulty finding primary care physicians and are often disappointed with the ability of primary care practices to meet their needs.[3,4]

We believe that a fundamental cause of these problems is the absence of an organizational framework for primary care that is connected directly to any robust strategy beyond that of increasing the volume of services for reimbursement. As we have asserted elsewhere,[5,6] we believe that the overarching strategy for health care should be to improve value for patients, where *value* is defined as patient outcomes achieved relative to the amount of money spent.

Only through achieving better outcomes that matter to patients, reducing the costs required to deliver those outcomes, or both can we unite the interests of all key stakeholders. Unless primary care is organized to deliver and demonstrate measured value, it will never command the respect and investment it needs. It will remain the underappreciated stepchild, recognized as necessary but not rewarded.

As organized today, primary care is a mission impossible. Most primary care practices attempt to meet the disparate needs of heterogeneous patients with a single "one size fits all" organizational approach. This leads to frustration for

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both patients and the clinicians who attempt to serve them.[5,6]

Ironically, the only way to improve value in primary care is to recognize that primary care is the wrong unit of analysis. We must deconstruct primary care, which is not a single set of services but a group of services delivered to meet the different needs of multiple subgroups of patients.

Even if a practice serves many or all of these subgroups, primary care teams should be organized around serving distinct subgroups of patients with similar primary care needs. Success in serving these subgroups—or "customer segments," as they are called in the management literature—will require new and better ways of measuring outcomes and costs, new mixes of skills, new ways of accessing patients, new payment models, and new approaches to integrating primary with specialty care.

These proposed changes are not theoretical. In fact, many of the recommended steps are already being taken by leading primary care practices,[7–11] including those where two of the authors practice primary care. However, we believe that most health care organizations currently operate without an overall strategy for improving primary care. Consequently, the hard work of clinicians is dissipated because of a lack of clarity about what they are trying to accomplish, and for whom.

Substantial barriers exist that would hinder a movement toward more value in primary care, particularly for practices of one or two physicians. However, the pressures for such practices to consolidate and reorganize are already evident and growing. The framework we offer here can help guide the transformation of primary care and potentially accelerate progress.

Defining 'Value' In Primary Care

Any useful organizational framework requires a clear goal, and the fundamental goal of primary care should be improving value for patients. This goal must transcend the traditional management focus on optimizing the financial performance of primary care practices under fee-for-service payments.

How does a value-based delivery model differ from care organized around performing reimbursed transactions such as office visits? In value-based delivery, care is organized around the patient and meeting a defined set of patient needs over the full care cycle. The aim is to improve health outcomes, and to do so with increasing efficiency.

To improve value, the measurement of both outcomes and costs is essential. Without these data, clinicians lack the information needed to validate choices, guide improvement, learn from others, and motivate collaboration and change. Value measurement is also needed to demonstrate the impact of innovations and justify additional investments.

For specific conditions such as heart failure or breast cancer, patients' needs are often well defined, as are common complications. For such care, value is often improved by multidisciplinary teams of clinicians that act as integrated provider units and collaborate to meet the major needs of their patients over the full cycle of care, including dealing with common comorbidities—not just providing discrete services.[12]

For example, integrated cancer teams increasingly include both palliative care specialists, to ensure that end-of-life care issues are addressed, and psychiatrists, to help diagnose and treat depression.[13] Increasing numbers of such condition-focused delivery units are being opened at institutions such as Massachusetts General Hospital's Institute for Heart, Vascular, and Stroke Care.[14]

In primary care, however, there are few such units. The core problem is that primary care is, by definition, focused on the whole patient—and the patients who seek primary care are heterogeneous.[15] The diversity of their needs creates the fundamental value conundrum in primary care and is the root cause of the difficulty in measuring that value. It is impractical to measure outcomes achieved relative to costs for a highly diverse set of patients, so the field defaults to performance metrics based on what physicians do and get paid for: volume of visits, panel size, and numbers of processes executed.

As a result, primary care practices have become "supply-based" organizations designed to maximize the production of services through the number of visits and fee-for-service reimbursement for discrete transactions. Clinicians work hard, but each patient is treated as a special case for whom "the wheel" must be reinvented.

Thinking about primary care as a single service not only undermines value but also creates a trap that makes value improvement difficult, if not impossible. We will never solve the problem by trying to "do primary care better." Instead, primary care must be redefined, deconstructing the work that goes on within those practices and rethinking how it is performed.

The Agenda For Primary Care

We believe that the path for transforming primary care lies in a shift to value-based patient subgroup management. This management

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approach consists of the five essential elements described next.

Basing Primary Care On Patients' Needs The first element, and the starting point for value-based primary care, is to identify groups of patients with similar needs, challenges, and ways to best access care. Then care teams and care delivery processes can be designed for each patient subgroup, outcomes can be measured, and the costs of providing the subgroup's care can be understood. Tailored measures of outcomes and costs that reflect each subgroup's needs and care cycle should replace current measures that focus on a provider's volume of reimbursable services.

The exhibit in the online Appendix[16] provides one simple framework for dividing adults into five subgroups that account for most adult primary care activity. For pediatric practices, children can be separated into analogous groups. The subgroups shown and the potential team members are illustrative and may differ to some extent by practice. For example, expectant mothers and mothers of young children may be an important subgroup in women's health practices. And in some practices, sociodemographic factors such as a high prevalence of Spanish-speaking patients may make ethnicity an important variable.

There is no universal best approach to grouping patients. What is critical is that each practice agree on a framework that captures most or all of the differing needs of its particular array of patients and that can evolve over time as learning accumulates about team-based delivery models.

▸**Using Subgroups To Meet Needs:** By grouping patients according to similarities in their needs, primary care practices can develop multiple "needs-based" delivery systems explicitly designed to measure and improve value. Dividing patients into subgroups not only enables providers to better meet the patients' needs but also enables the increased anticipation of needs and the delivery of appropriate preventive care.

Within each subgroup, there will always be variation and the need to tailor care for individual patients, even if the majority of patients find that the majority of their needs are well met. For example, the subgroup of healthy adults will include people with slightly different risk factors and varying urgent care issues but who share the same basic requirements for maintaining optimal health—that is, screening and preventive care services and evaluation for acute issues.

Similarly, the subgroup of patients with multiple chronic conditions and frequent exacerbations will share a need for more frequent and intense interactions with the health care system, a wider set of services, and a broader team of clinicians and supporting staff—including the appropriate specialists, patient educators, and coordinated home health care services—to help manage their illnesses, in comparison to healthy patients.

"Needs" include not only types of services but also effective methods for patients to access care. For example, a generally healthy twenty-six-year-old woman with a urinary tract infection may not need to come into the office for a face-to-face appointment. In contrast, a forty-five-year-old woman with poorly controlled diabetes mellitus will benefit from frequent interactions with a diabetes educator, combining in-person visits with phone or Internet interactions focused on regular monitoring and behavioral change.

There is a widely held notion among clinicians that getting patients into the office for nearly any reason is inherently good because it offers opportunities to provide screening and preventive services.[17] From a value perspective, that strategy is an expensive approach to screening patients; it is also likely to miss many of them.

Dividing patients into subgroups is not based on segmenting the population by discrete diseases such as diabetes, hypertension, and depression. Rather, the division is based on similarities in the types of care needed, which reflect patients' conditions and the severity of those conditions. Disease-based subgroups are appropriate for specialty care. But although they are tempting for primary care, they are impractical in that field. There are so many serious medical conditions and possible "disease management" programs in most primary care practices that each one would cover only a small percentage of a practice's patients. Such fragmentation makes the task of developing integrated teams by disease overwhelming, and most primary care practices simply give up before starting.

▸**Implications For Primary Care Redesign:** To redesign primary care, the task is to divide the entire patient population served by a practice into a relatively small number of groups that capture the main differences in core needs and circumstances. The focus should be on those groupings that will translate into differences in care team composition and service delivery needs. A given patient may occasionally move among subgroups over time, but his or her care is best managed and measured at any given moment by the team that is focused on and equipped to meet the patient's current needs.

A practice may choose not to serve all subgroups itself, referring some patients to other providers better equipped to meet particular needs. For example, patients with end-stage renal disease may be referred to a dialysis team that

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provides primary as well as nephrology care.

No system of dividing patients will ever capture all of their differences, but this approach is far superior to the status quo—which often involves no targeted efforts to meet patients' needs other than addressing their acute complaints. Clinicians may believe that their job is to treat every patient as if he or she were special. In fact, patients' needs would be better met if such a personalized approach were complemented by systematic efforts that addressed the common needs patients shared with others in their subgroup.

INTEGRATING DELIVERY MODELS BY SUBGROUP Once primary care practices have defined patient subgroups, they can move to the second essential element: developing teams that are focused on care integration and improvement for each subgroup. For most primary care practices, the development of effective teams that are true drivers of care integration would be the greatest departure from the status quo.

The critical issues are the following: Who is on the team? How do members work as a team across the care cycle? In what kinds of facilities? At what locations, and using what tools to best access and interact with patients?

▸**WHO IS ON THE TEAM?** Teams normally consist of primary care physicians together with other skilled staff who deliver the services needed by a particular patient subgroup. Physicians and other personnel play different roles on teams organized around the various subgroups. Tasks should be allocated among staff to use highly trained physicians and nurses where their skills are needed, and to use supporting personnel where appropriate.

For example, some organizations such as Geisinger Health System give front office staff responsibility for ensuring that preventive tests, such as eye examinations for patients with diabetes, are scheduled. Nonphysician clinical personnel—including medical assistants, nurses, and pharmacists—can track the management of common chronic conditions such as hypertension, diabetes, and lipid abnormalities.

Scheduling patients in a particular subgroup can be prioritized on defined days of the week. For example, patients with common chronic diseases can be preferentially scheduled on certain days to facilitate efficient visits and allow for group educational programs. Many practices have already implemented group visits for patients with certain common conditions, such as diabetes, heart failure, headache, and arthritis.[18]

When the scheduling of patients with various chronic conditions is concentrated, specialists most relevant to common comorbid conditions can join the team. For example, diabetes sessions can include endocrinologists, podiatrists, and nephrologists. Complex case sessions can include mental health specialists, palliative care consultants, and social workers. Timely consultations—both formal and informal—can occur readily if patients are scheduled according to needs instead of at random, and the types of clinicians most relevant to their needs are assembled at those times.

Such innovations seem radical departures from the norm, but this is only because of the absence of teams accountable for improving value for patient subgroups. When such teams are formed, these innovations become common sense. Within any given subgroup of patients, there will always be opportunities to improve. Even if outcomes are already excellent, teams can find ways to achieve them with greater efficiency.

In addition, practices may excel with one patient subgroup, but there will always be ways to improve in others. For example, a primary care practice might perform well in meeting the needs of patients with complex conditions but still have tremendous room for improvement in how it meets the needs of healthy or at-risk patients.

Organizing care delivery around the needs of patient subgroups challenges the notion that variety—for example, seeing a perfectly healthy patient followed by another who is catastrophically ill—should be a major source of satisfaction in practicing primary care. We think that physicians gain greater satisfaction from delivering excellent care, made possible by deep experience with a set of patients' needs and the ability to work with a team of colleagues who are well equipped to address them. Learning from colleagues with special expertise is also facilitated through such team care.

▸**HOW SHOULD OFFICE LAYOUT CHANGE?** Such a "needs-based" approach has implications for the physical layout, equipment, and on-site testing services of primary care practices. Practices tend to use outpatient space in ways that maximize the number of visits. Instead, space should be designed to facilitate the effectiveness of the teams.

For example, some primary care practices have been redesigned to put physicians and the personnel with whom they work in closer proximity, so they can collaborate more reliably. One approach is to have "flow stations," in which the physician and medical assistant sit adjacent to each other and deal with paperwork together.

Many practices now include common workrooms for clinicians and support staff, so that clinicians can interact spontaneously with each other and with schedulers and other

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administrative personnel in between contact with patients in examination rooms. Mental health specialists or other types of clinicians—including palliative care consultants, pain specialists, and psychiatrists—may also work out of such shared space, potentially on designated days during the week.

Each subgroup team should develop its own patient access model. Although services will continue to be provided at traditional locations, teams should also access patients via the Internet and telephone; at home and in satellite locations, such as schools and workplaces; and using other nontraditional mechanisms.

For example, home visits are often more effective than office visits for frail elderly and disabled patients. The pharmacy is among the places with the most frequent patient contact for those with chronic conditions such as hypertension and diabetes, and it can be integrated into care models. For most types of patients, huge potential value improvement can be achieved through the adoption and use of patient portals into electronic health record systems, to permit two-way communication between patients and their clinicians.

▶**HOW SHOULD TEAM MEMBERS WORK TOGETHER?** Providers must function in teams to be effective. Each team must have a recognized leader who is accountable to the organization's leadership for improvement in value for its patient subgroup. The team should meet regularly to review performance on the specific metrics—for example, outcomes and costs—that define *value* for its patient subgroup. Team members should also have continuous informal interaction, which is why it is important to have common space where such interactions can occur.

Monthly one-hour practice meetings, with ten to fifteen minutes of each meeting focused on reviewing performance for a patient subgroup, might be a practical formal coordination model. Incentives, both financial and nonfinancial, should be used to reward teams for improvement in performance.

The team leader need not always be a primary care physician. In some new practice models, for example, nonphysicians have primary responsibility for preventive care for healthy patients or for the management of patients with stable chronic diseases. This preserves the time of physicians for what they are trained to do best, while increasing job satisfaction for nonphysician staff because they are integral to patient care and not just support providers.

MEASURING VALUE FOR EACH PATIENT SUBGROUP The third element of the agenda for primary care is to measure outcomes and costs for each patient, by subgroup. The ultimate measures of success are outcomes that matter to patients, not the process measures that now dominate "quality" measurement in primary care.

▶**IDENTIFY OUTCOMES THAT MATTER TO PATIENTS:** The relevant outcomes differ among subgroups, which confounds any effort to measure primary care outcomes as a whole. Furthermore, within any patient subgroup, no single outcome defines performance; instead, multiple outcome measures need to be collected on an ongoing basis. A fundamental goal of outcomes measurement is for teams to identify opportunities to learn from others, because no primary care practice is likely to be superb on all outcomes.[5]

Exhibits 1 and 2 consist of samples of outcome scorecards for healthy adult patients and for adult patients with chronic illnesses. For subgroups involving chronic illnesses or complex conditions, outcomes will be a combination of general outcome measures, such as quality of life and timeliness of care, and specific measures for the particular chronic conditions or illnesses involved, such as diabetes. Considerable work lies ahead in developing measures and implementing measurement systems, but that should not prevent health care organizations from getting started by using what data are available.

▶**MEASURE TOTAL COSTS:** Measuring total costs, including those outside of primary care, for patients in each subgroup is also part of creating value scorecards. Existing costing systems fall far short of capturing actual costs per patient.[19] Accurate costing begins with process mapping, or understanding all of the care processes involved in serving a patient subgroup over time, including common pathway variations such as the need for an interpreter's services or reviewing radiographic images from outside providers. Then the resources involved in each process—for example, personnel, equipment, space, drugs, and supplies—can be identified and their costs ascertained and aggregated.

By comparing the outcomes achieved with the actual costs incurred, delivery organizations can measure the improvement of value for each patient subgroup. Subgroup teams and their leaders will be equipped to take on their most essential work—improving value—by improving one or more outcomes without compromising performance on others, or lowering the costs required to deliver those outcomes. Then delivery organizations will be able to justify and make thoughtful investments in staff, equipment, and facilities.

ALIGNING PAYMENT WITH VALUE The fourth element of the agenda for primary care is to align payment with value. Progress in primary care

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EXHIBIT 1

Potential Outcome Measures For A Value Scorecard For Healthy Adult Patients

Measure	Specifics of measure
Survival	Mortality
Degree of recovery or health	Functional status (physical and mental health)
Time to recovery or return to normal activities	Time to treatment for minor urgent care issues Time to definitive diagnosis for more complicated conditions Time spent accessing treatment Time to complete specialist treatment for more complicated or urgent issues Work days missed due to lack of full physical or mental function
Disutility of care or treatment process	Pain and anxiety prior to treatment Pain and anxiety during treatment Care complications
Sustainability of recovery or health over time	Maintained functional level Frequency of minor urgent care issues Frequency of major acute issues (such as cancer, myocardial infarction, stroke) Acuity of chronic conditions and complications (such as hypertension, diabetes)
Long-term consequences of therapy	Side effects of care received

SOURCE Authors' analysis.

payment reform has been paralyzed by the current fragmentation of health care delivery, which is a natural result of fee-for-service payment. Paying for each discrete service separately reinforces the idea that the work of primary care organizations should be driven by discrete services or supplies.

▸**BUNDLED PAYMENTS:** We believe that a payment system designed around time-based bundled payments, or payment for a total package of services for a defined primary care patient subgroup during a specified period of time, is the approach most aligned with value for patients.

For example, primary care practices could receive different monthly payments for the care of patients in different groups. The payments might be $5 per month for a healthy patient, $10 for one who is at risk, $25 for one with a chronic disease, and $100 for a patient with a

EXHIBIT 2

Potential Outcome Measures For A Value Scorecard For Adult Patients With Chronic Illnesses

Measure	Specifics of measure
Survival	Mortality
Degree of recovery or health	Functional status (physical and mental health) Control of complications of chronic disease
Time to recovery or return to normal activities	Time spent accessing treatment Time to access specialist treatment for more complicated or urgent issues Work days missed due to lack of full physical or mental function
Disutility of care or treatment process	Pain and anxiety prior to treatment Pain and anxiety during treatment Care complications Need for emergency department visits or hospitalizations
Sustainability of recovery or health over time	Maintained functional level Frequency of minor urgent care issues Frequency of major acute issues (such as cancer, myocardial infarction, stroke)
Long-term consequences of therapy	Side effects of care received

SOURCE Authors' analysis.

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complex condition. Additional fee-for-service payments could be available for addressing patients' acute care needs, although payments for such visits would be less than under a pure fee-for-service model.

Using the proportions of subgroups of patients described in the online Appendix,[16] such a payment structure would yield about $600,000 per year in payment for the primary care practice, based on per member per month funding for a typical physician panel of 2,500 patients. That amount would be sufficient to fund the additional nonphysician personnel needed for true "team care." Risk adjustment and outlier provisions could help protect a practice from financial exposure resulting from high-risk patients with complex conditions.

▸**PRIMARY CARE INCENTIVES:** Even when overall delivery organizations operate under global budgets for large patient populations—for example, under capitation, which pays a fixed sum per patient—episode-based financial incentives for specialty care or internal subgroup-based incentive systems for primary care will be needed to reinforce integrated care and improve value at the provider level. Clinicians have difficulty responding to the imperative to reduce spending in a fee-for-service system with anything besides arbitrary cuts and discontent. Bundled payments for the care of specific patient groups, in contrast, enable more thoughtful choices for primary care providers and reward improvement.

The fragmentation of services in most provider organizations has slowed the voluntary shift to bundled payments for episodes of care, but the mechanics of bundle implementation are increasingly being explored and understood.[20] Given the growing imperative for value, provider organizations will face greater pressure to organize clinicians to support value improvement and embrace new approaches to reimbursement for specific patient subgroups. If bundled payment models for the patient subpopulations defined in the Appendix[16] or others are put in place, we believe that primary care value improvement will accelerate.

INTEGRATING SUBGROUP TEAMS AND SPECIALTY CARE The final component of the strategic agenda for primary care is to integrate primary care patient subgroup teams with relevant specialty care teams. Just as patient subgroups differ in what they need from primary care practices, they also vary in what they need from secondary and tertiary care providers.

Healthy children or adults will have most of their health care needs met through primary care practices. Other patients, such as those with serious conditions that are treatable but not curable, will ideally receive much of their care from clinicians working in an integrated specialty care unit. Such patients will benefit from formal coordination and integration between the primary care and specialty teams.

Experiments are under way in which specialists are embedded in primary care practices and primary care providers are embedded in specialty practices. The ideal combination of primary and specialty care will vary by patients' subgroup and medical condition, and even for individual patients across time. The ability to manage this variation requires that primary and specialty care providers function as members of a joint team, organized around meeting the needs of patients. Clinicians then have the shared goal of improving outcomes and efficiency for their common patient, rather than simply performing their particular jobs.

This collaboration requires systematic efforts to share protocols, define handoffs, and build personal relationships. Integration is most likely to succeed if all providers have access to the same clinical information system, and if consistent outcomes data are being routinely collected and shared. Of course, having bundled payment systems that reimburse primary care and specialty clinicians as a group for a given patient increases the likelihood that they will collaborate.

Putting Value-Based Primary Care Into Practice

Although we have described a strategic redesign of primary care, the concepts here are not radical. Many innovative primary care practices are already implementing some elements of a value-based model of primary care.

For example, "ambulatory intensive care units" focus on the sickest or most expensive patients, using teams to improve outcomes and lower overall costs. Organizations such as the Commonwealth Care Alliance and CareMore are providing high-value primary care to a subgroup of disabled and elderly patients using targeted delivery models involving home visits and comprehensive sets of supporting services.[9] Intermountain Healthcare, the Department of Veterans Affairs, and Cherokee Health Systems have all implemented primary care models in which primary care staff and behavioral health specialists work in the same location and together serve patients who need both types of care.

The patient-centered medical home is an important step toward better-coordinated, team-based care that has the ability to improve outcomes and lower costs.[21–24] However, the largest

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investment required to become a patient-centered medical home (besides electronic health record systems) is employing nurse case managers who focus on improving the coordination of care for the high-risk patients who constitute only 3–5 percent of a typical practice's patient population. This model does not explicitly address the organizational challenge posed by the heterogeneity among primary care patient subgroups and the differences in what constitutes excellent performance among them. For example, care management systems that follow elderly high-risk patients through telephone contacts and office visits with case managers have less success using the same approach with younger high-risk patients, who are often difficult to contact via telephone (Mark Mandell, Partners Community Healthcare, personal communication, September 30, 2012).

The patient-centered medical home is in many ways "necessary but not sufficient" to implementing a value-based primary care framework. In other words, it is unlikely to solve the fundamental value challenge on its own. At worst, patient-centered medical homes could become just an overlay, in which care coordinators manage dysfunction instead of changing the underlying delivery structure.

Practices that apply patient-centered medical home standards simply through adding a patient registry and more care coordination personnel are unlikely to improve the value of care delivered and may see costs rise. However, practices that use the implementation of patient-centered medical homes as an opportunity to divide patients into subgroups, build truly integrated teams to serve them, measure subgroup-specific outcomes and costs, and focus on process improvement may dramatically improve value in primary care.

The concept of organizing teams around patient subgroups may seem disruptive to the holistic approach and integrative nature of primary care practices. But it is actually likely to make the provision of holistic and integrative care more efficient. Health care often gets paralyzed by concerns about meeting the needs of exceptions, thereby losing the opportunity to implement systems that meet the majority of needs for the majority of patients, including patients with exceptional needs. Patients' needs may shift, and some patients will never fit neatly into any specific subgroup. But our clinical experience in primary care suggests that there is not really any conflict between systems that meet the needs of patient subgroups and the delivery of personalized care to each individual.

Practice Size As A Barrier

An obvious and important factor affecting the adoption of a value-based primary care framework is practice size. Providers in small practices—those with just one or two physicians—are likely to believe that they do not have the scale to develop separate teams for distinct patient subgroups. Such practices are already struggling to manage the cases of high-risk patients and adopt electronic health records, along with other systems that have the potential to improve outcomes and efficiency.

We believe that the trend toward larger primary care practices will continue. Nonetheless, small practices will remain common for years to come, especially in rural settings, and such practices can collaborate in the adoption of this framework without giving up their business independence. For example, they can form networks with an umbrella structure that enables them to measure outcomes and costs, negotiates payments with appropriate incentives, and provides the human and information systems that can increase value. The imperative to improve the value of health care is likely to propel the development of such new relationships.

Conclusion

Conditions have never been more favorable for a fundamental redesign of primary care. We are now at a moment of discontinuity in health care delivery, when changes in the payment system and the culture of medicine are possible and indeed probable. New payment models such as accountable care organizations offer an impetus and opportunity for value-based patient management, as providers recognize the benefits of organizing themselves around particular subgroups of patients to better serve their needs. By pursuing the strategies described above, we can drive collaboration and true integration of care, thus meeting society's imperative to substantially improve the value of primary care. ■

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Michael E. Porter is the Bishop William Lawrence University Professor at the Harvard Business School.

In this month's issue of *Health Affairs*, Michael Porter and coauthors describe a framework for deconstructing and reorganizing primary care practices around subgroups of patients with similar needs. Teams of providers would care for patients over full "care cycles," patients' outcomes and the true costs of care would be measured; and providers would be compensated through payment bundles that would stimulate them to improve value. The authors argue that such changes would amply reward primary care and cause it to "command the respect and investment it needs."

Porter is the Bishop William Lawrence University Professor at the Harvard Business School. His core fields of interest are company strategy and the competitiveness of nations and regions. He has assisted numerous national leaders on strategies for economic development and, since 2001, has devoted considerable attention to research on value-based health care delivery, with a special focus on strategy, organization, reimbursement, and value measurement of health care delivery organizations. Recently, Porter cofounded the International Consortium for Health Outcomes Measurement, devoted to accelerating and standardizing outcome measurement globally. Porter earned an MBA and a doctorate in business economics from Harvard University.

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Thomas H. Lee is a professor at the Harvard School of Public Health and Harvard Medical School.

Thomas Lee is a primary care physician at Brigham and Women's Hospital, network president at Partners HealthCare, a professor of health policy and management at the Harvard School of Public Health, and a professor of medicine at Harvard Medical School. The theme of his management career, research, and teaching has been the development and evaluation of strategies that improve the quality and efficiency of care.

Lee serves on numerous committees, including the board of directors of Geisinger Health System and Geisinger Health Plan, the Panel of Health Advisers at the Congressional Budget Office, the Committee on Geographic Variation in Health Care Spending at the Institute of Medicine, and the Special Medical Advisory Group at the Department of Veterans Affairs. He is also an associate editor of the *New England Journal of Medicine*. Lee earned a master's degree in epidemiology from Harvard University and a medical degree from Cornell University.

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International Federation of Health Plans

2012 Comparative Price Report

Variation in Medical and Hospital Prices by Country

International Federation of Health Plans

The International Federation of Health Plans was founded in 1968 by a small group of health plan industry leaders. It is now the leading global network in the industry, with more than one hundred member companies from twenty-five countries.

Federation member plans meet regularly to share information about health care financing and health care delivery in their home countries.

2012 Survey Overview

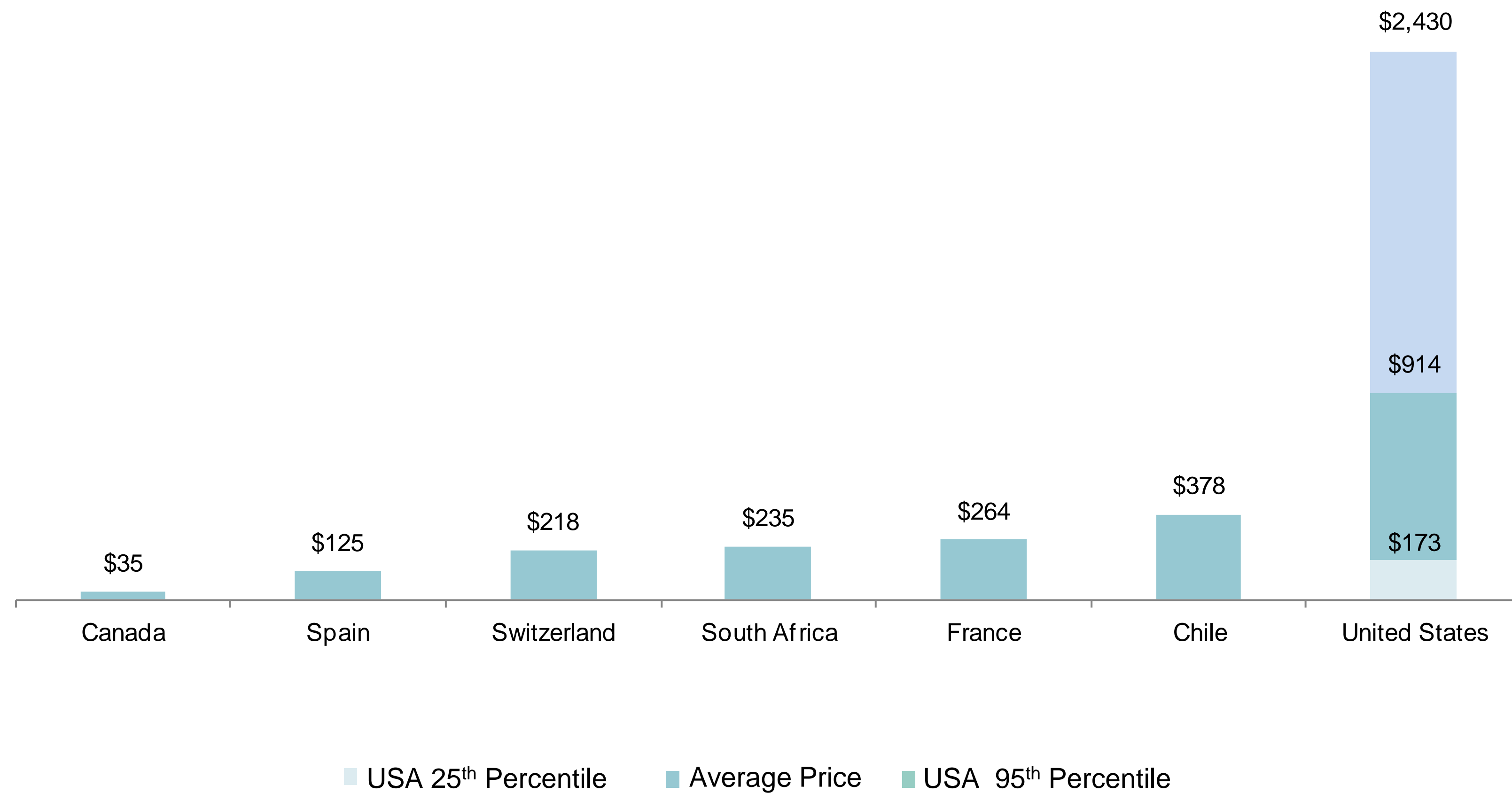
This year's survey includes new prescription drug prices in response to increased interest in this area from plans in many countries. We have also added three new non-drug items to our survey: hip prosthesis, knee replacement, and colonoscopy.

Prices for each country are submitted by participating federation member plans, and are drawn from different sectors:

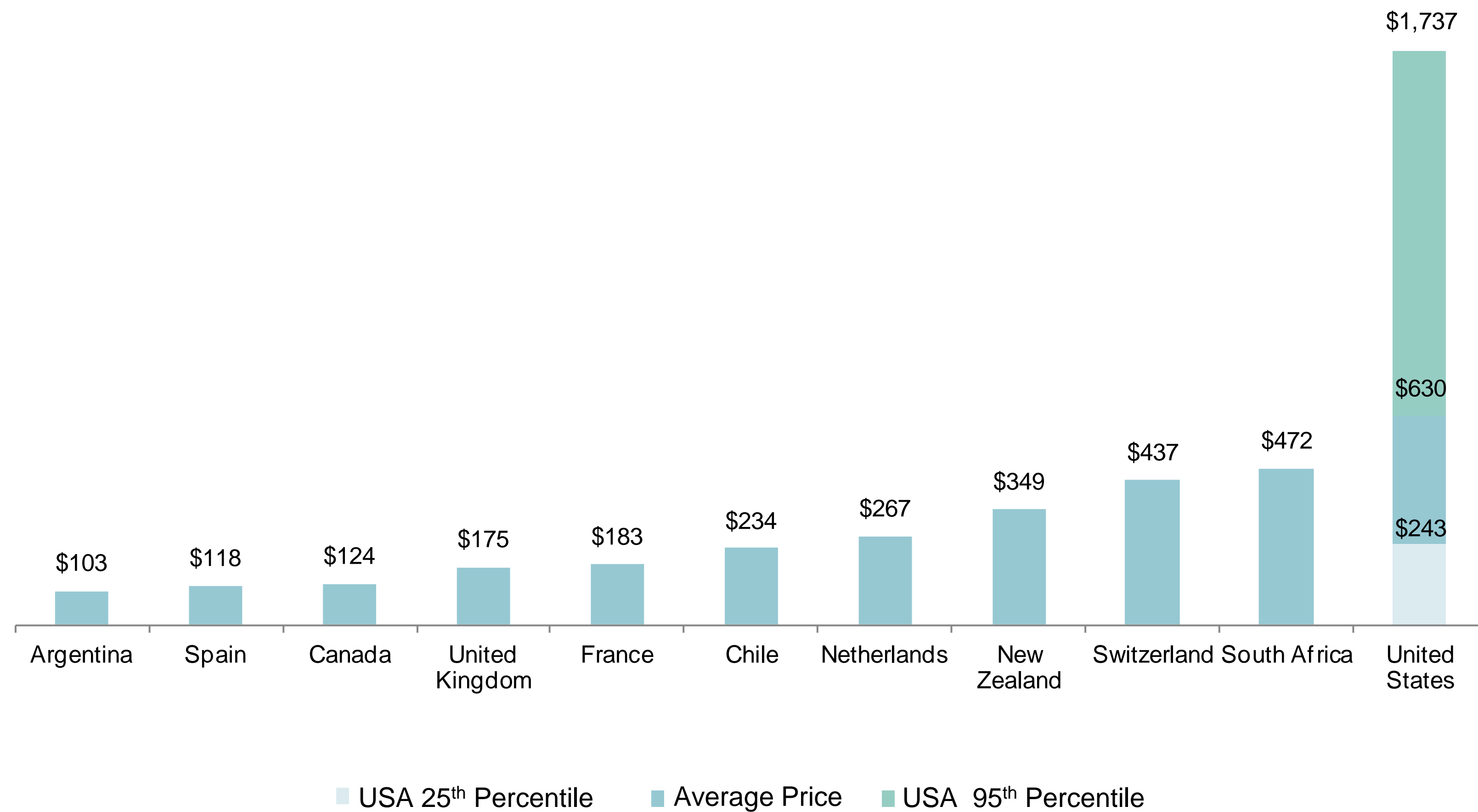
- Prices for Canada, New Zealand, Switzerland, and the United Kingdom are from the public sector, with data provided by one health plan in each country.
- Prices for Australia, Chile, the Netherlands, Spain, and South Africa are from the private sector and represent prices paid by one private health plan in each country.
- Prices for France and Argentina are a blend of public and private sector prices with the data provided by one health plan in each country.
- Prices for the United States are calculated from a database with over 100 million paid claims that reflect prices negotiated between thousands of providers and almost a hundred health plans.

Comparisons across different countries are complicated by differences in sectors, fee schedules, and systems. In addition, for some countries a single plan's prices are real for that plan but may not be representative of prices paid by other plans in that market. The U.S. numbers are based on an aggregate of over a 100 million paid claims across multiple payers.

2012 Scanning and Imaging: Angiogram

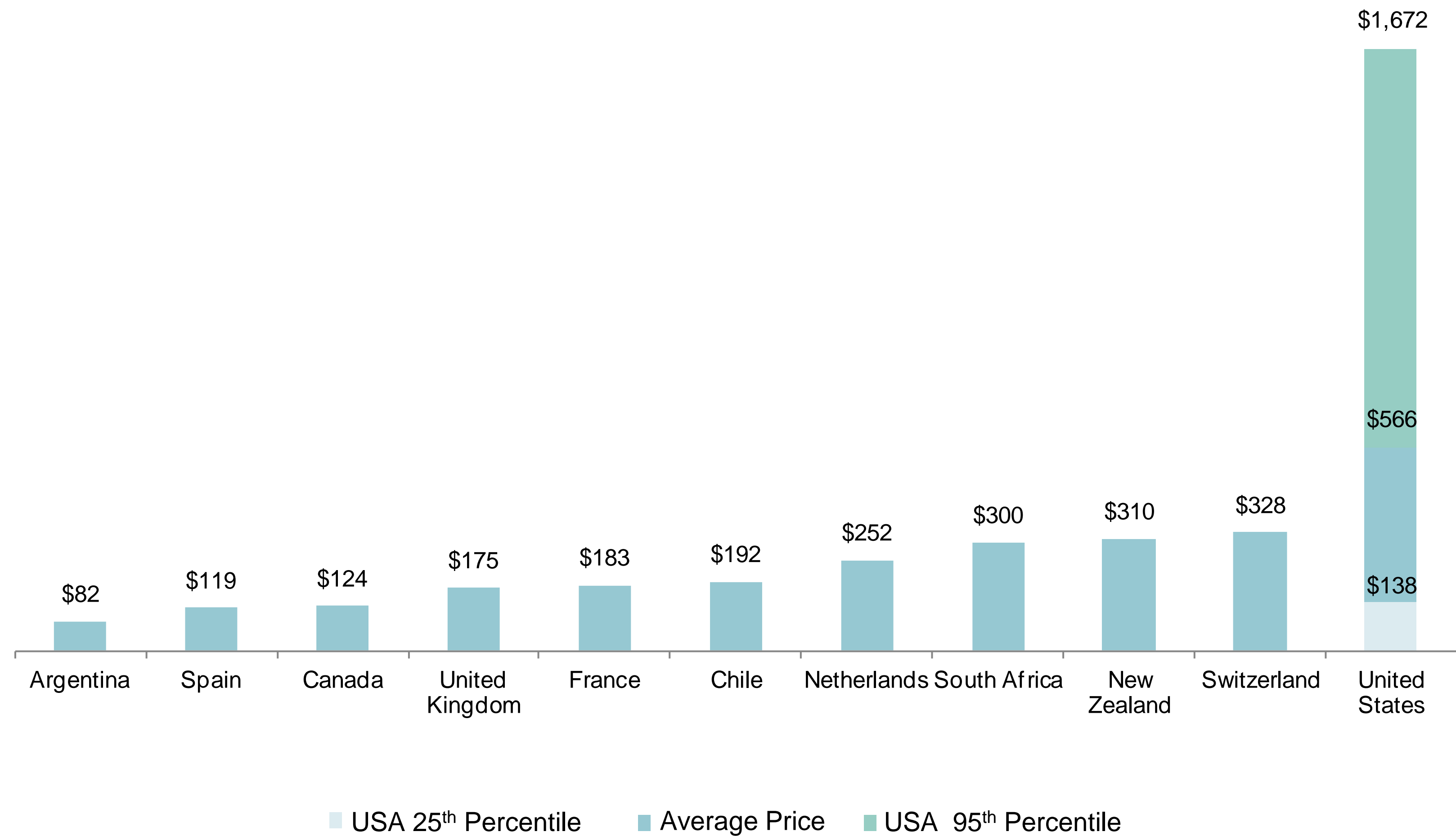


2012 Scanning and Imaging: CT Scan, Abdomen

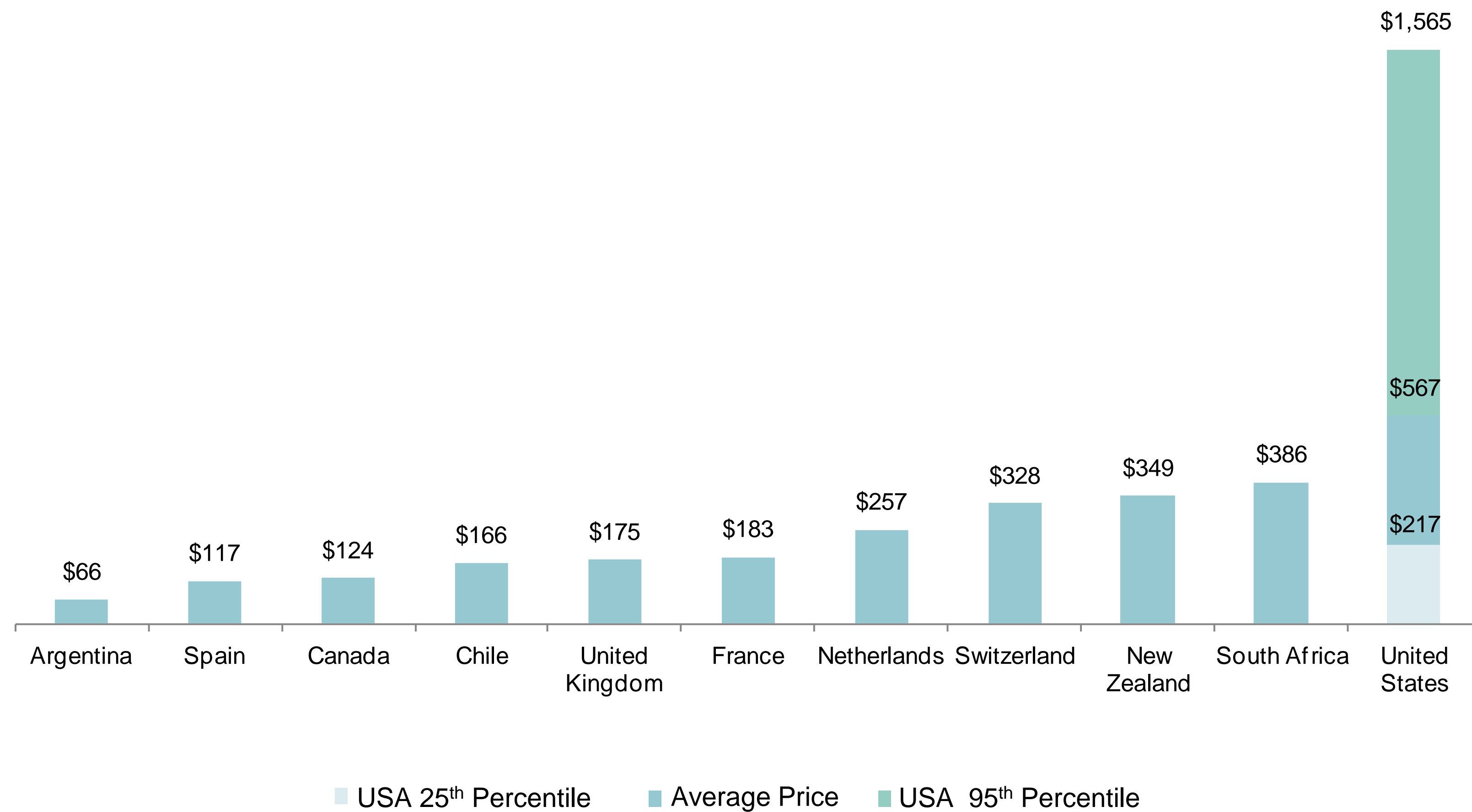


($ USD)

2012 Scanning and Imaging: CT Scan, Head

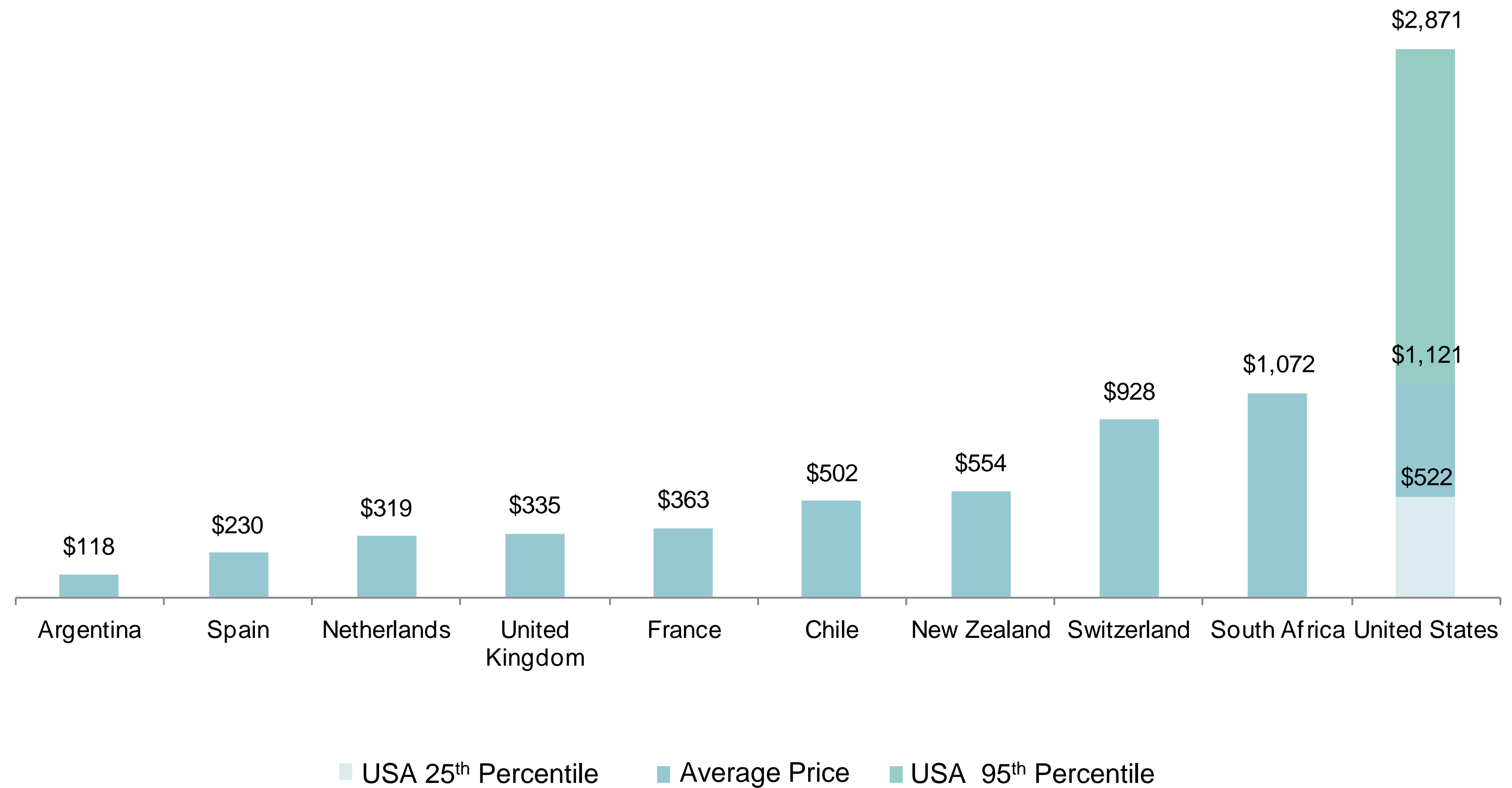


2012 Scanning and Imaging: CT Scan, Pelvis

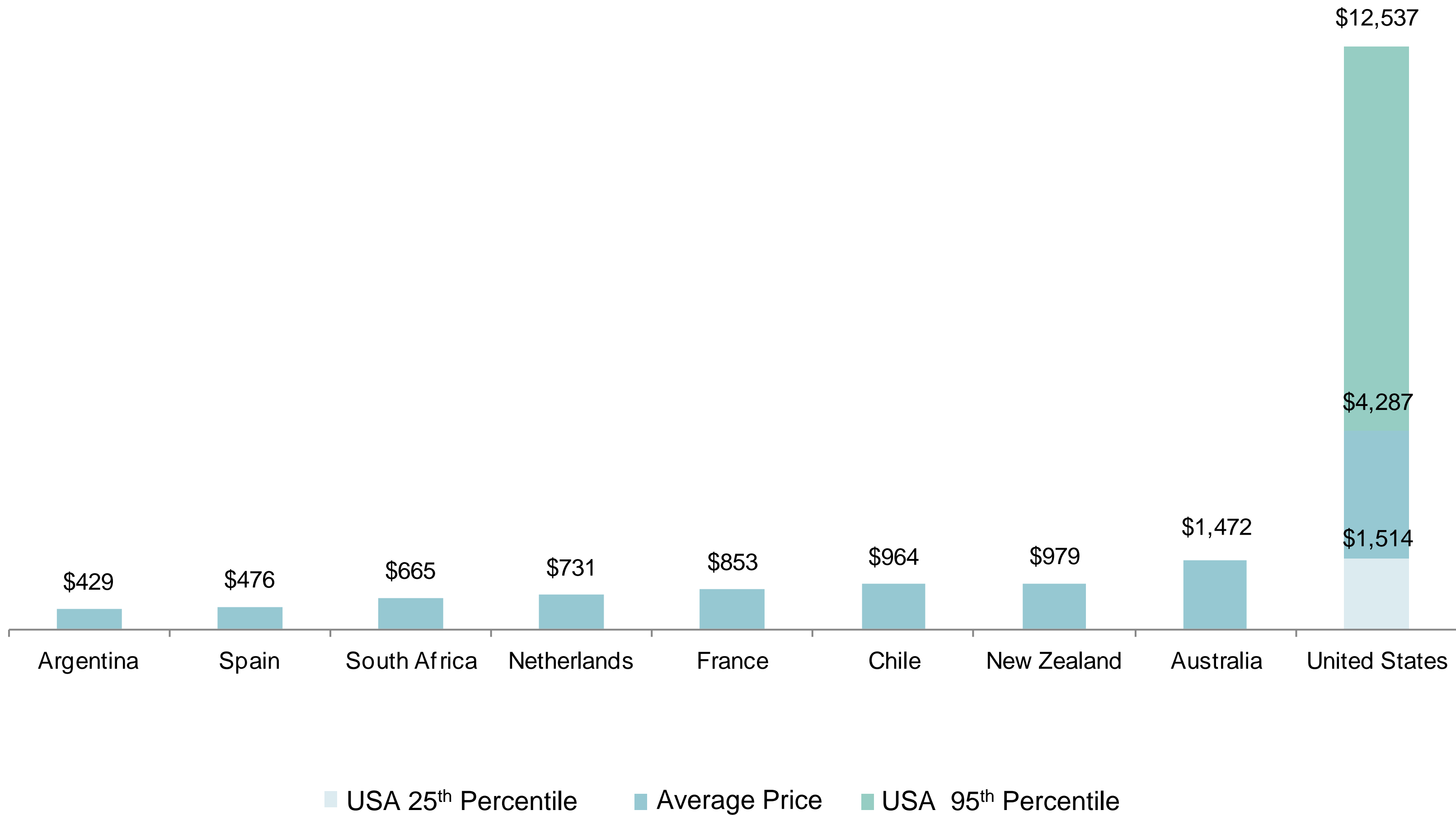


($ USD)

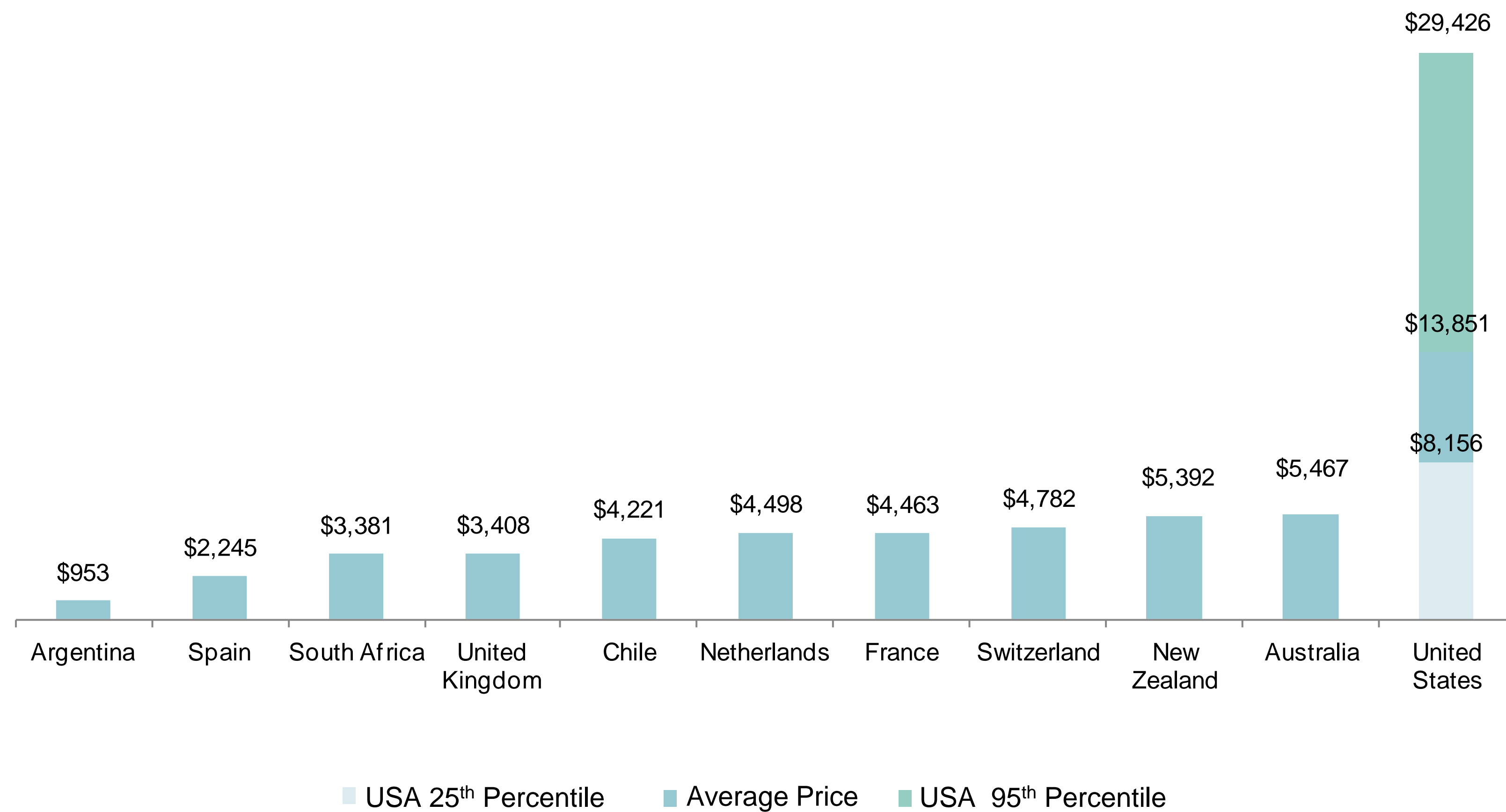
2012 Scanning and Imaging: MRI



2012 Cost Per Hospital Day

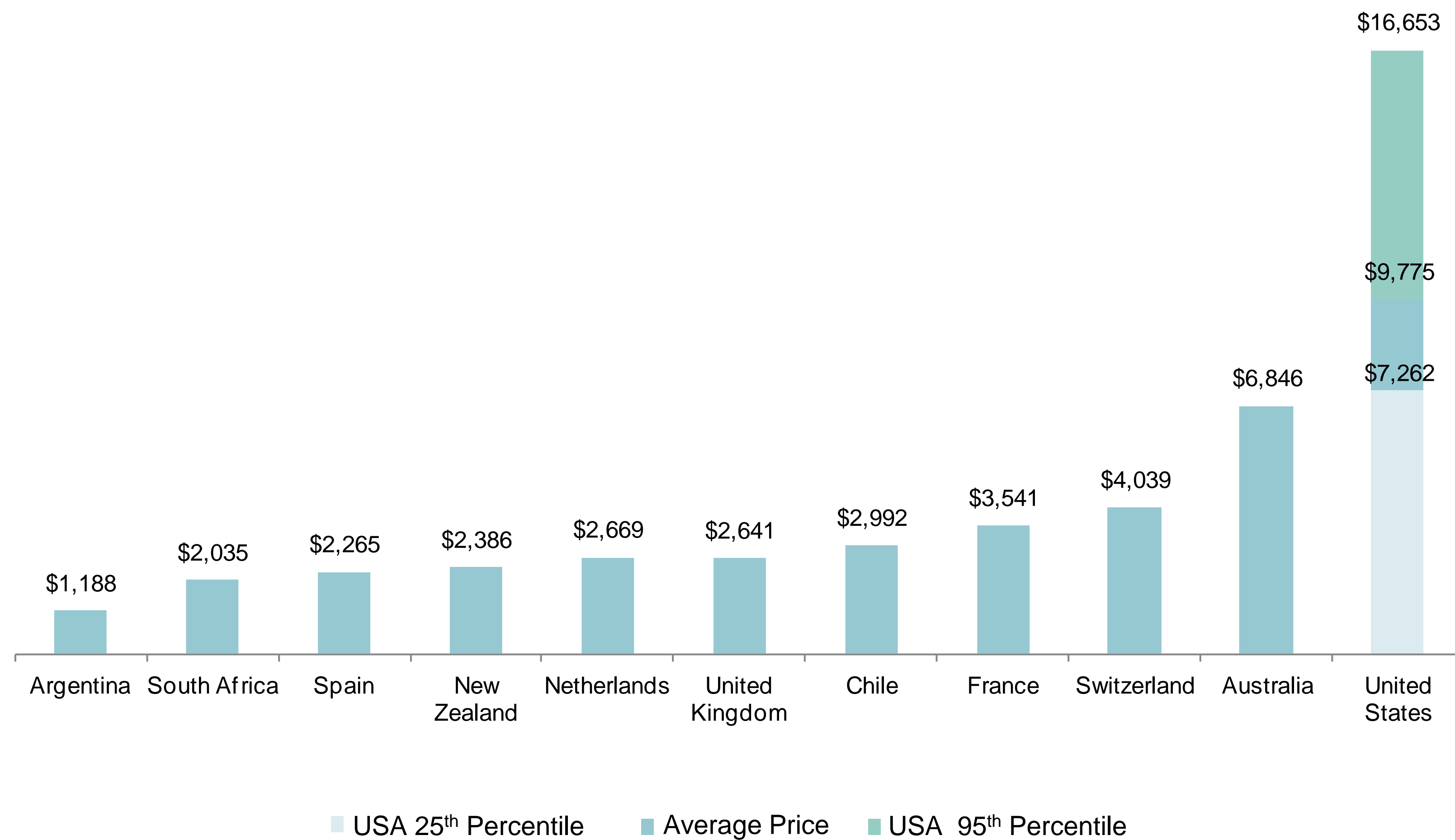


2012 Total Hospital and Physician Cost: Appendectomy



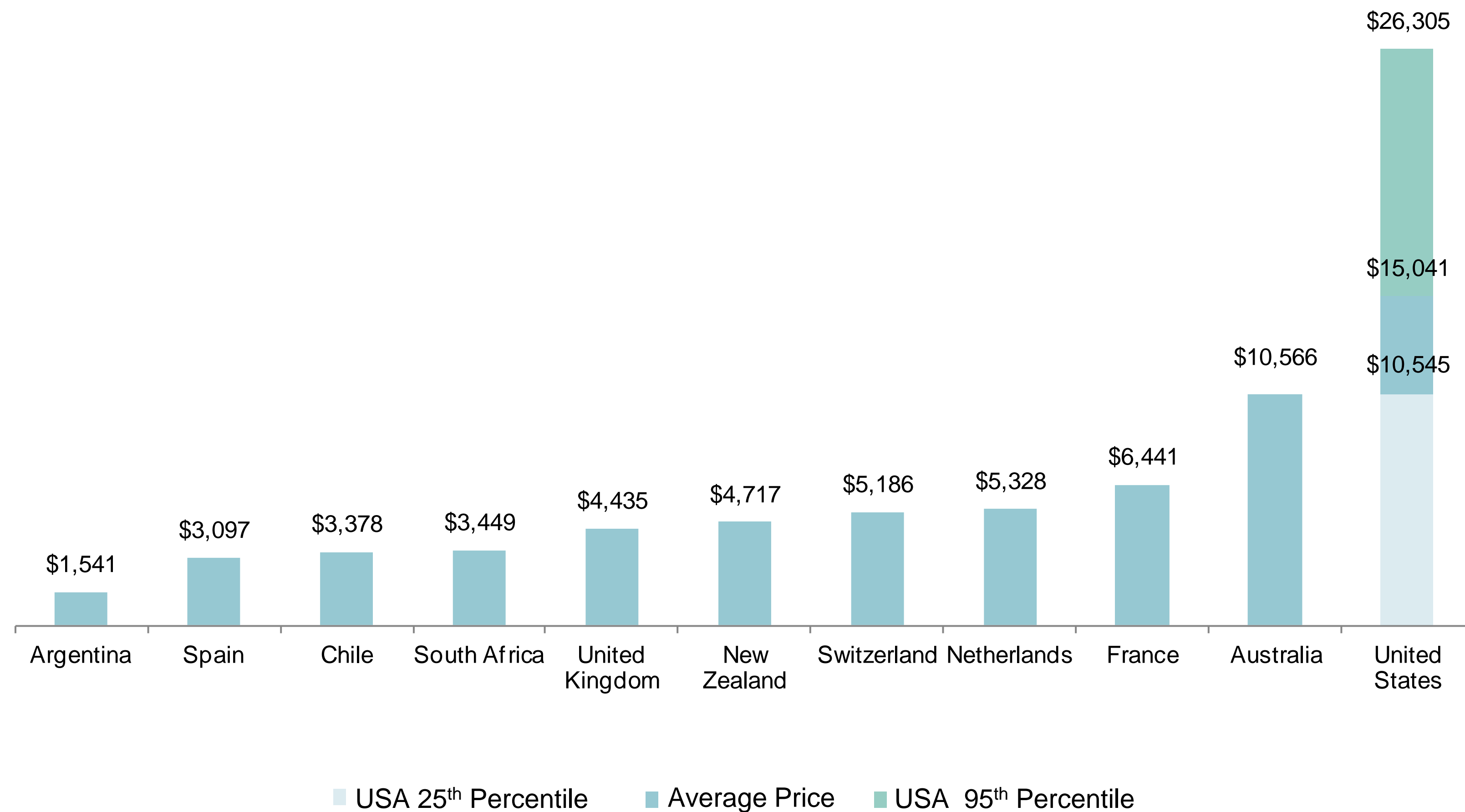
($ USD)

2012 Total Hospital and Physician Cost: Normal Delivery

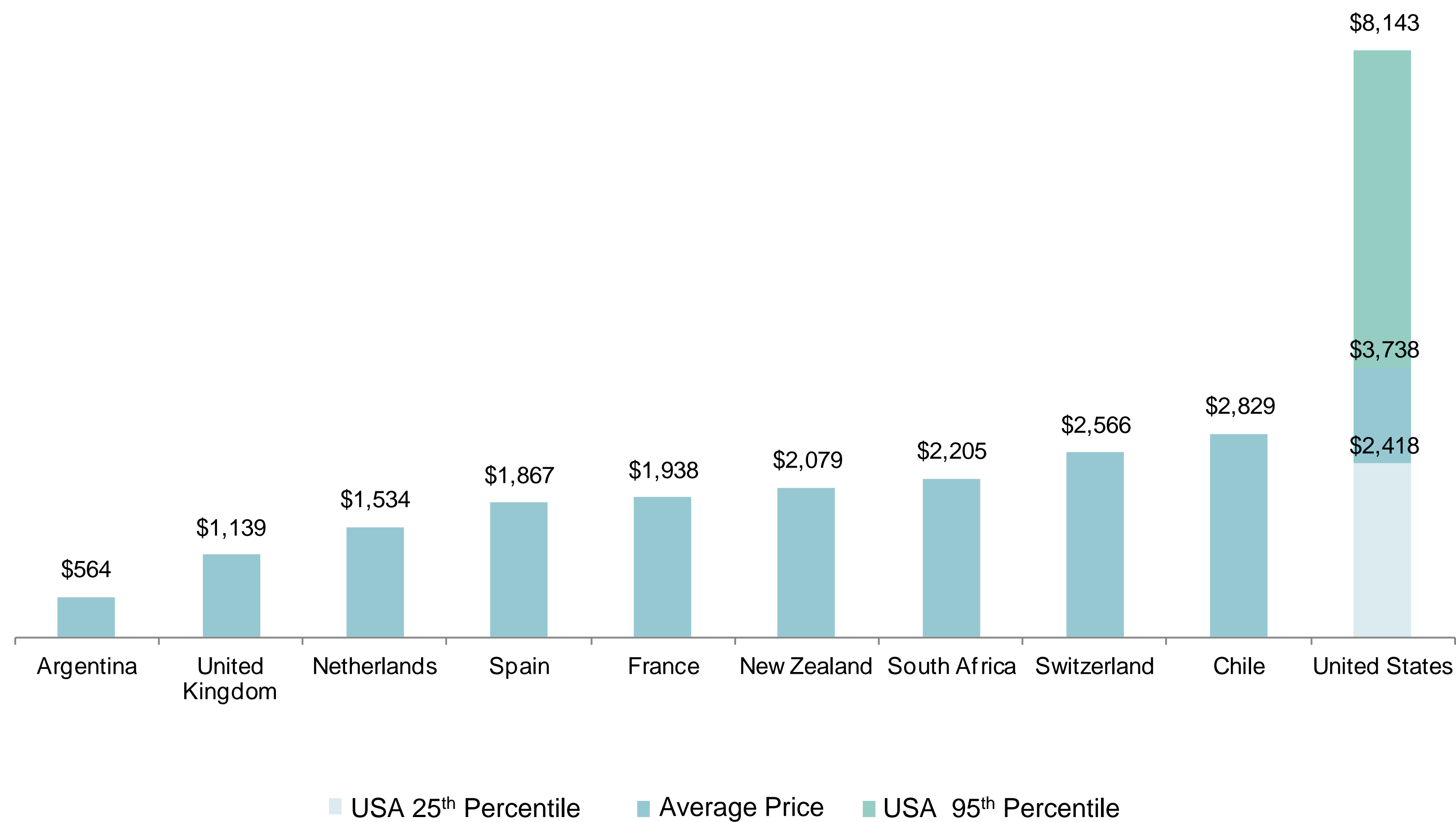


($ USD)

2012 Total Hospital and Physician Cost: C-Section

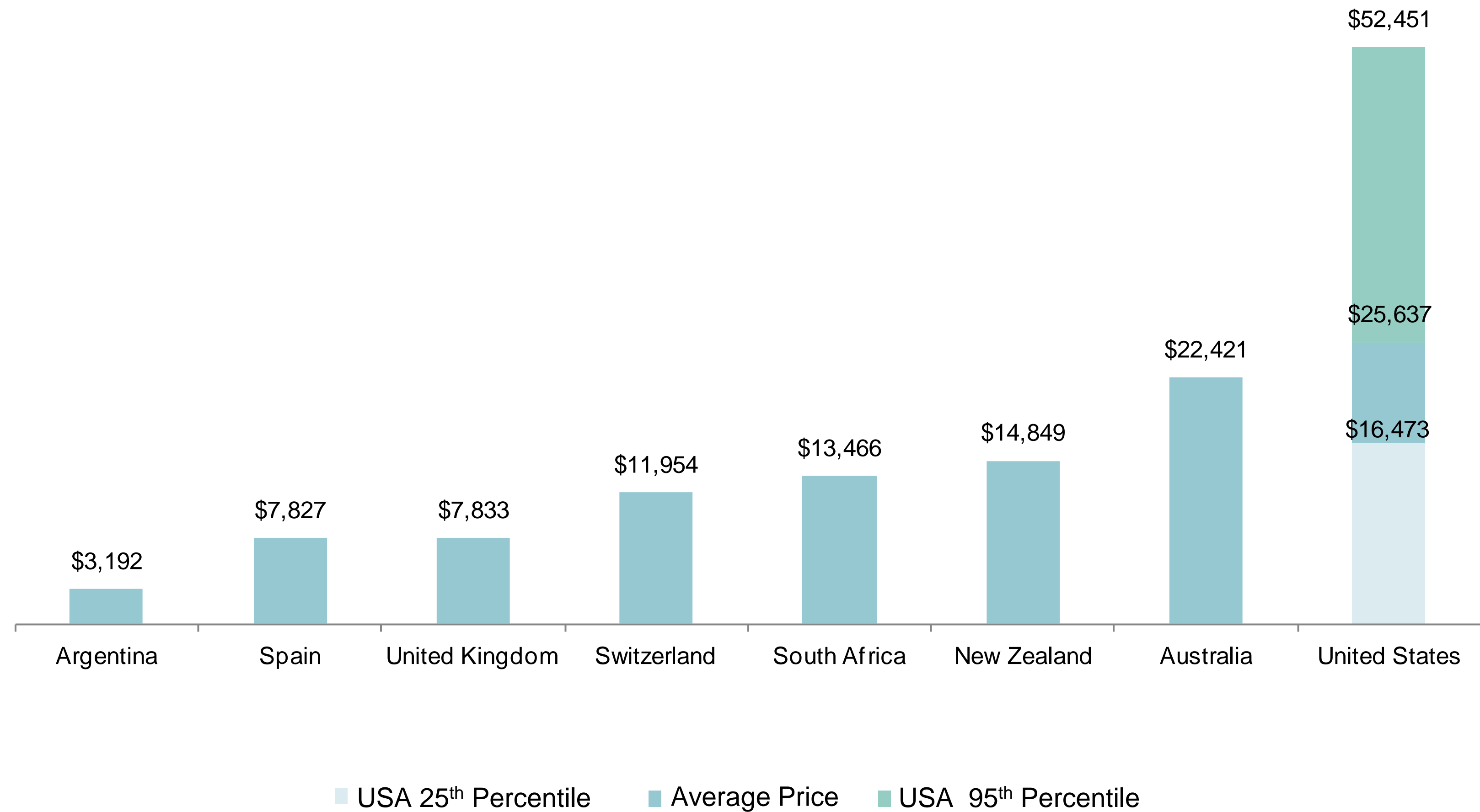


2012 Total Hospital and Physician Cost: Cataract Surgery

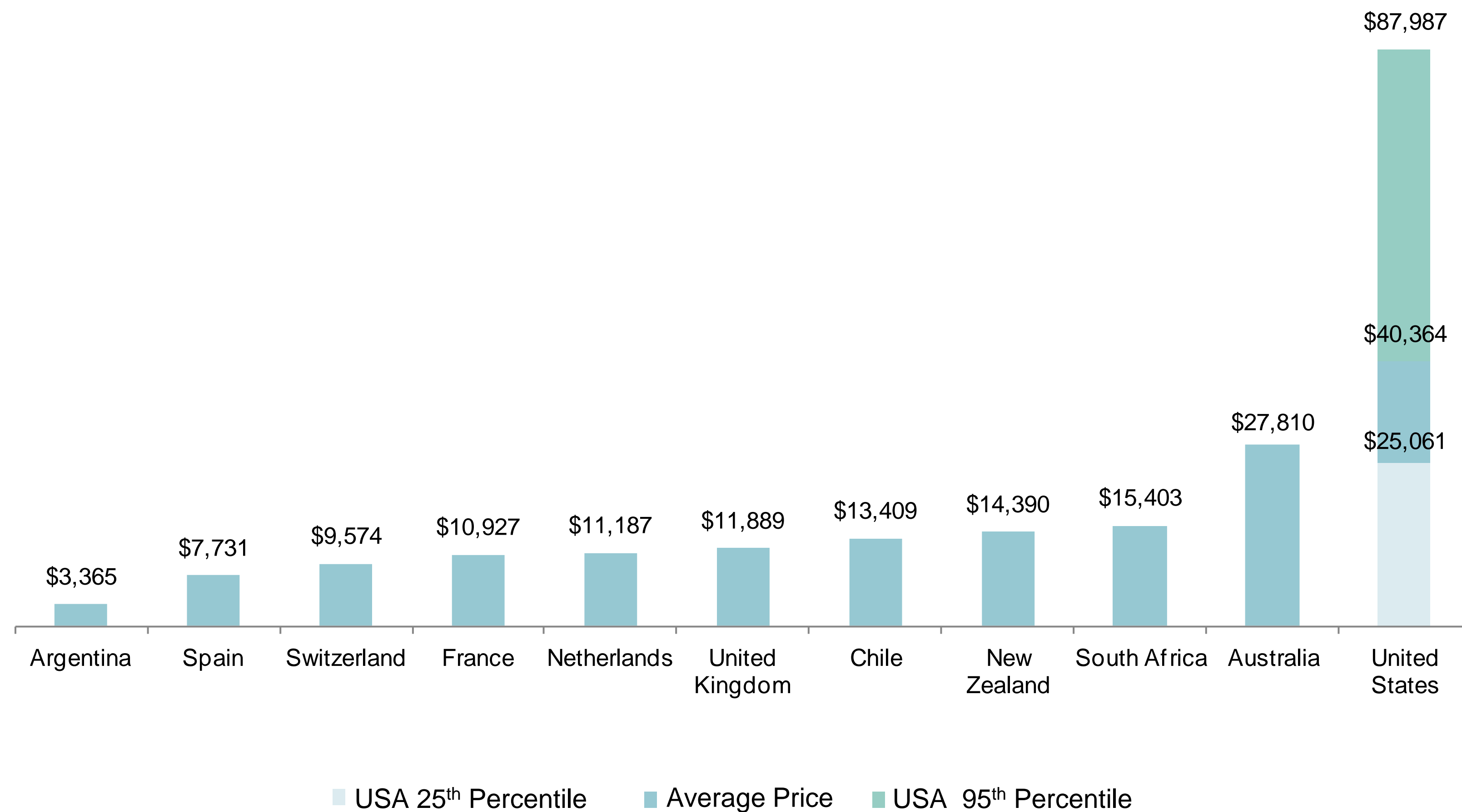


($ USD)

2012 Total Hospital and Physician Cost: Knee Replacement Surgery

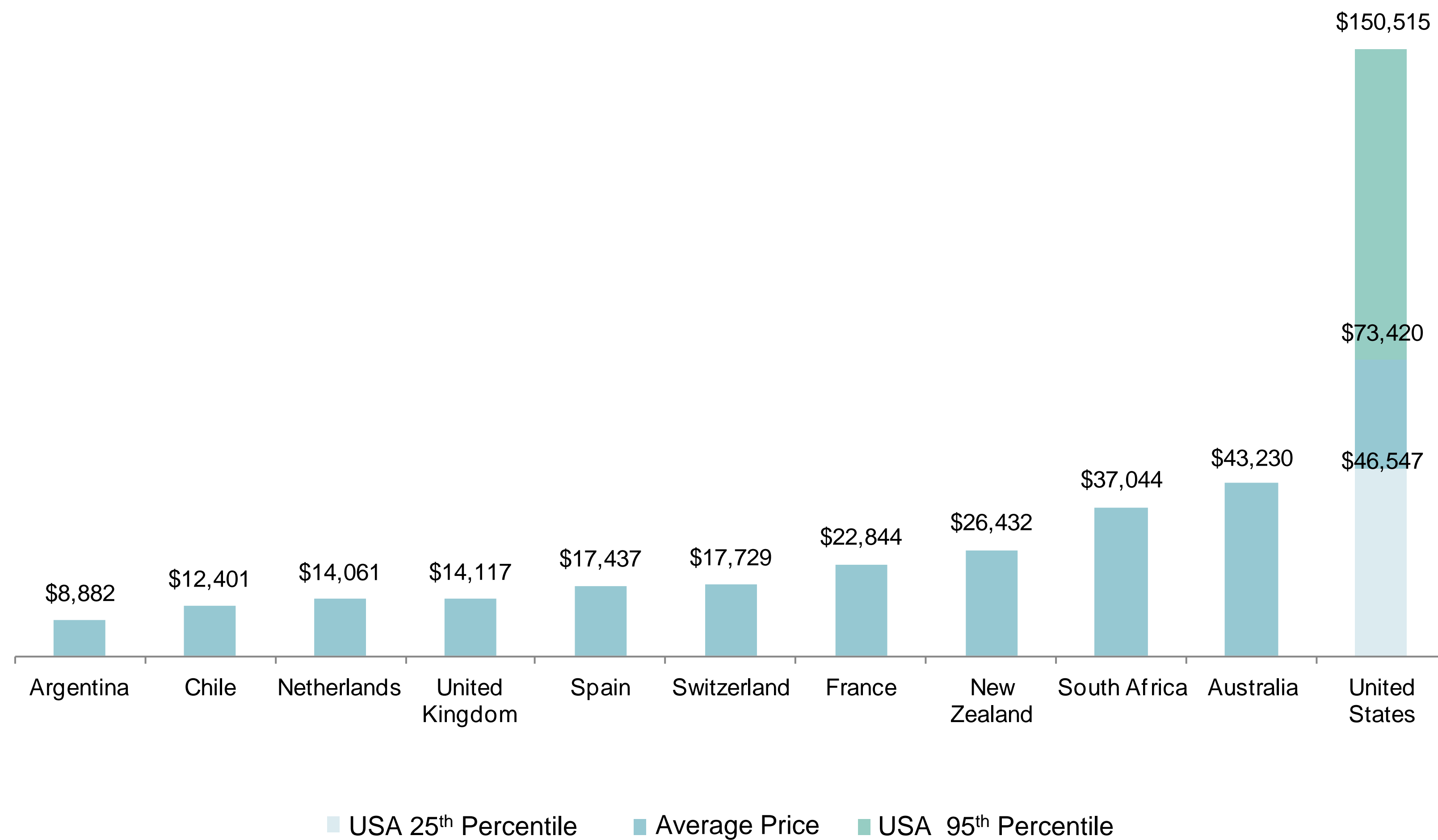


2012 Total Hospital and Physician Cost: Hip Replacement



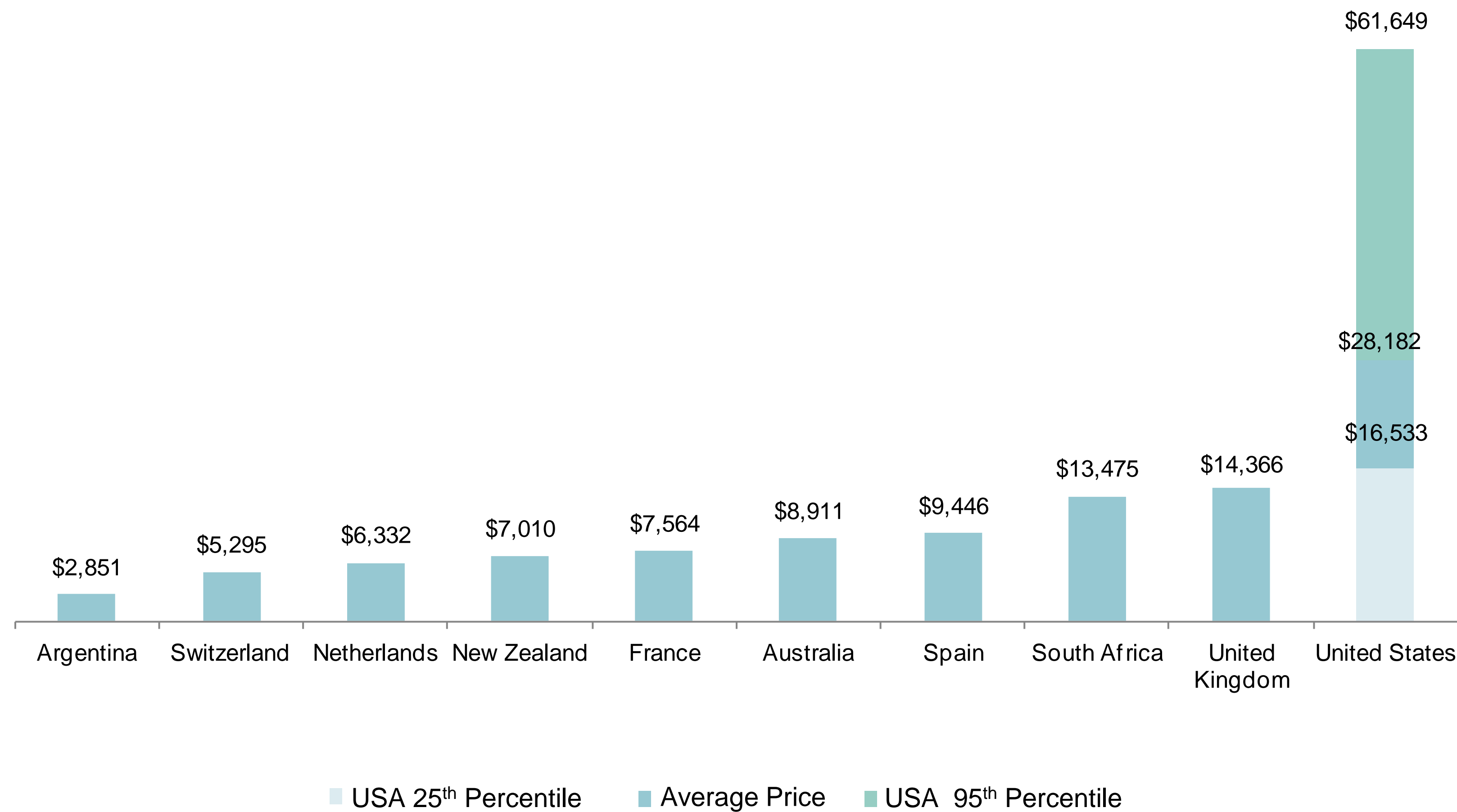
($ USD)

2012 Total Hospital and Physician Cost: Bypass Surgery



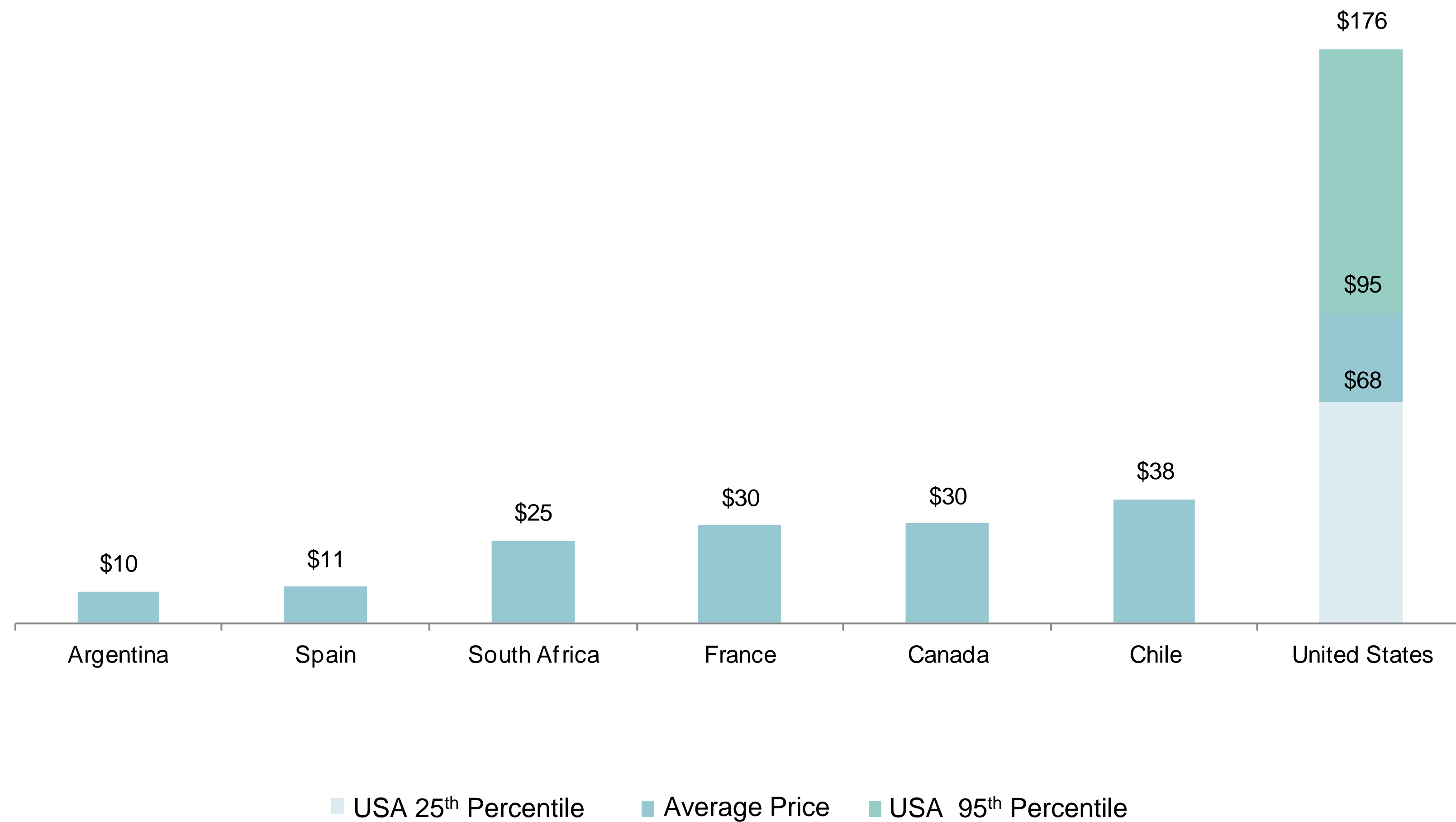
($ USD)

2012 Total Hospital and Physician Cost: Angioplasty

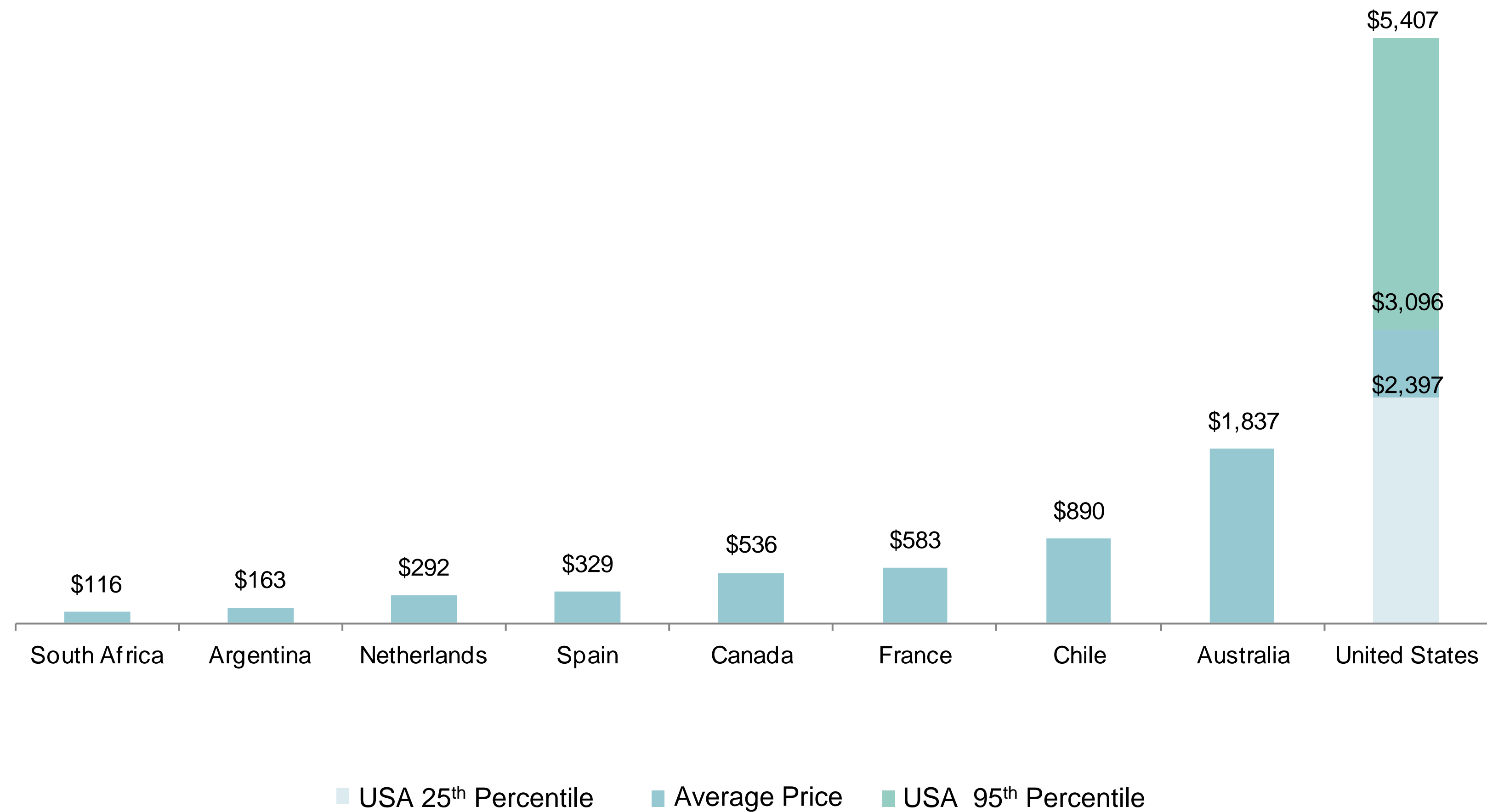


($ USD)

2012 Physician Fees: Routine Office Visit

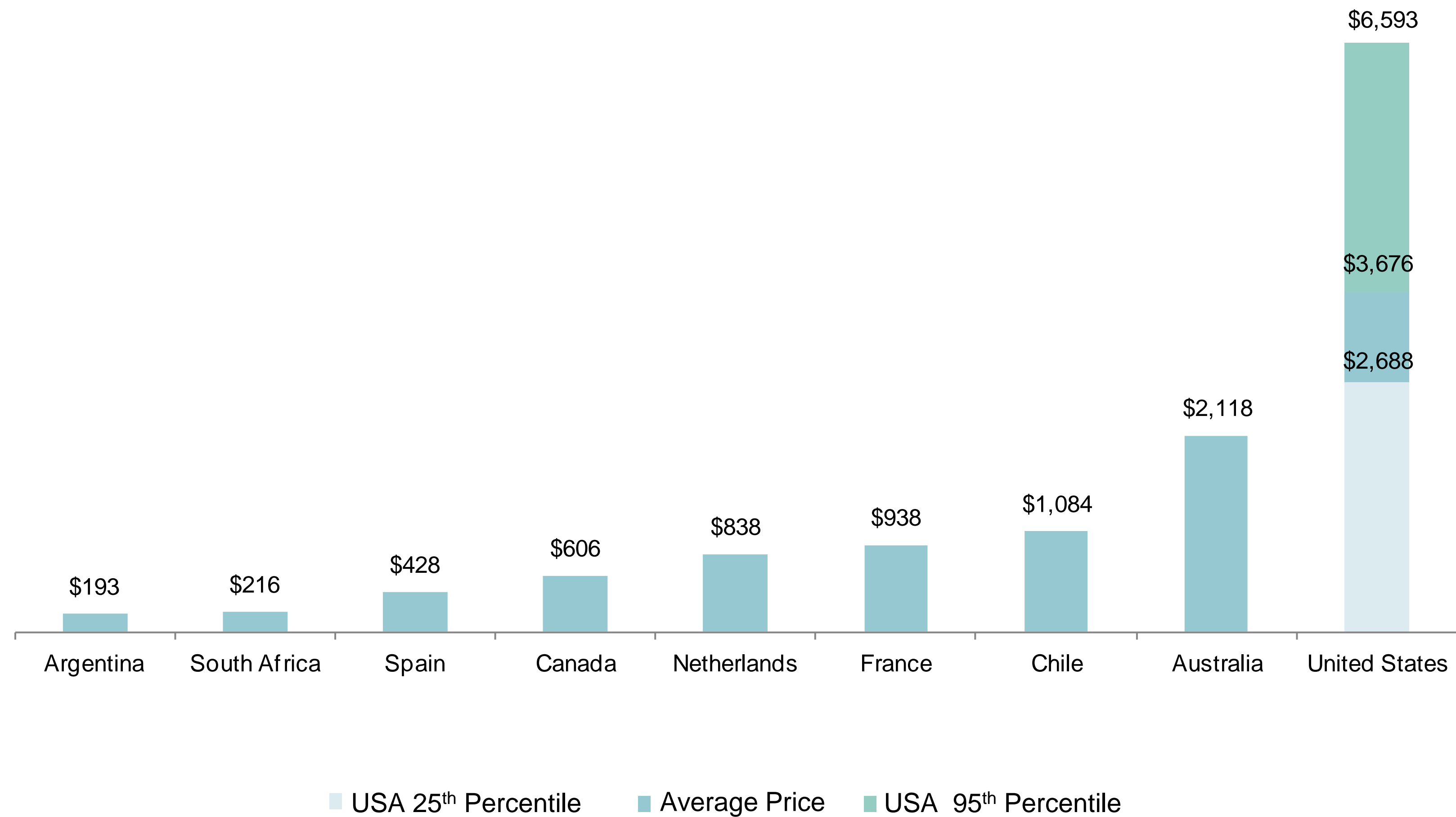


2012 Physician Fees: Normal Delivery



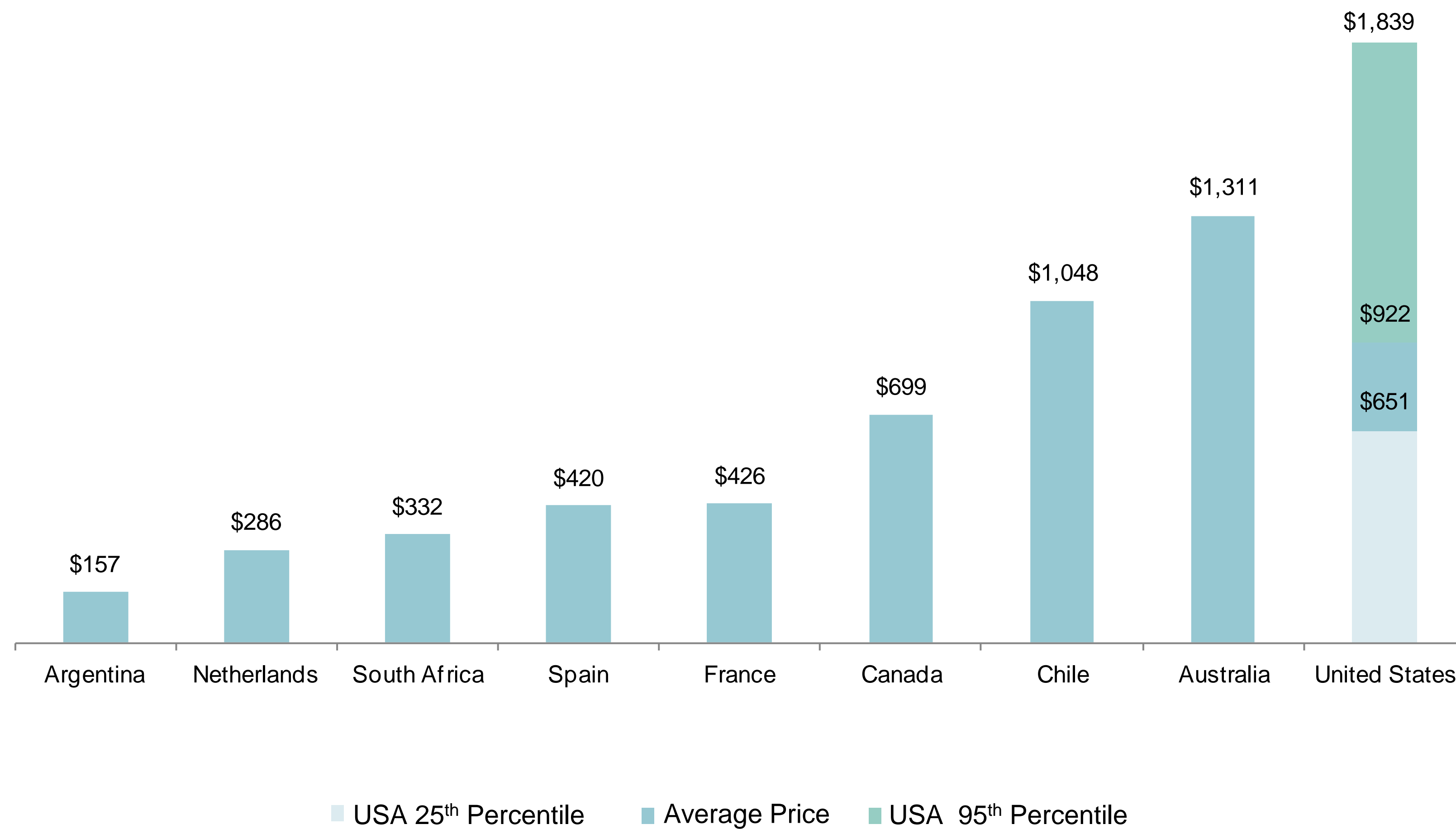
($ USD)

2012 Physician Fees: C-Section



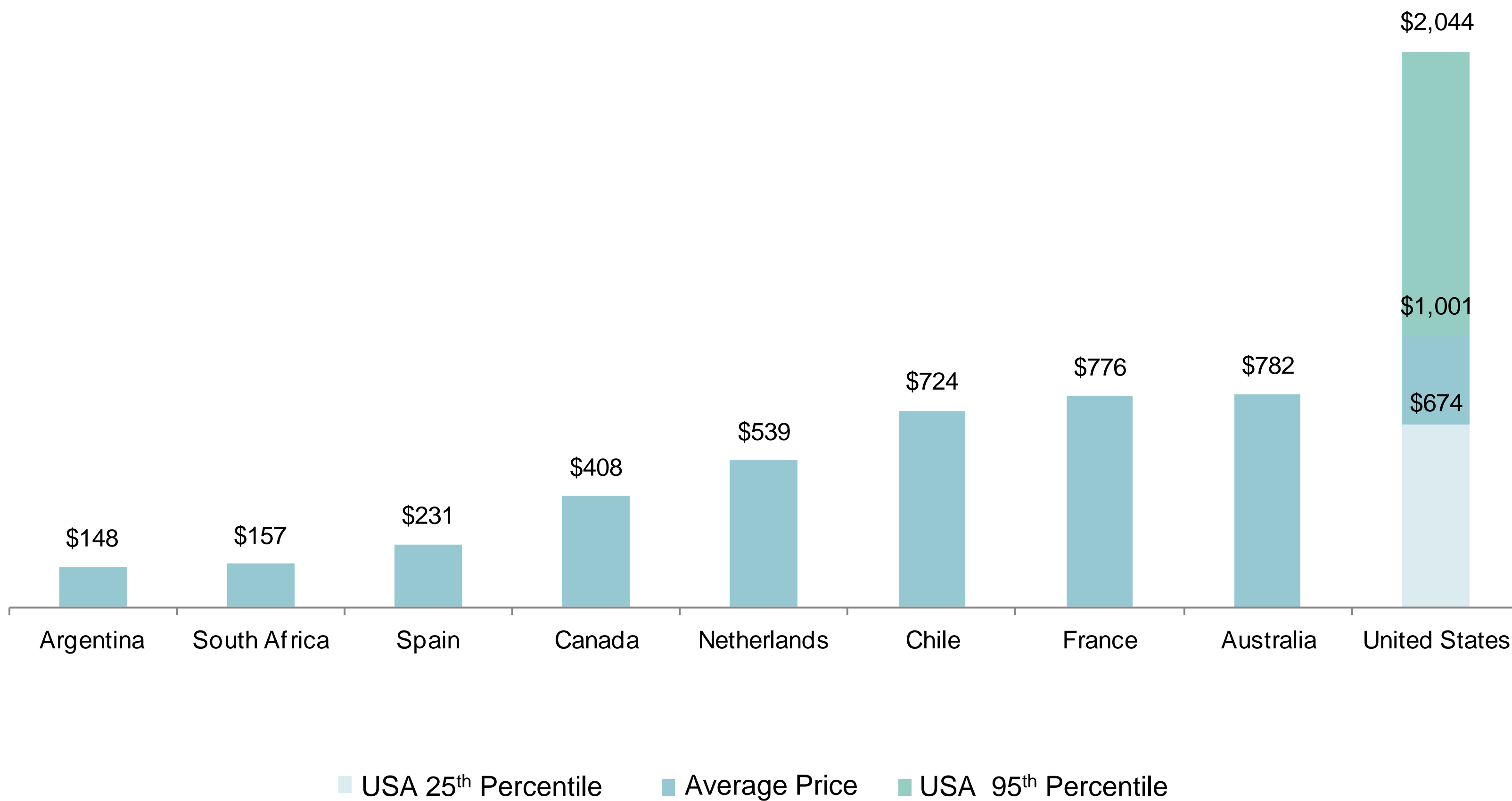
($ USD)

2012 Physician Fees: Cataract Surgery



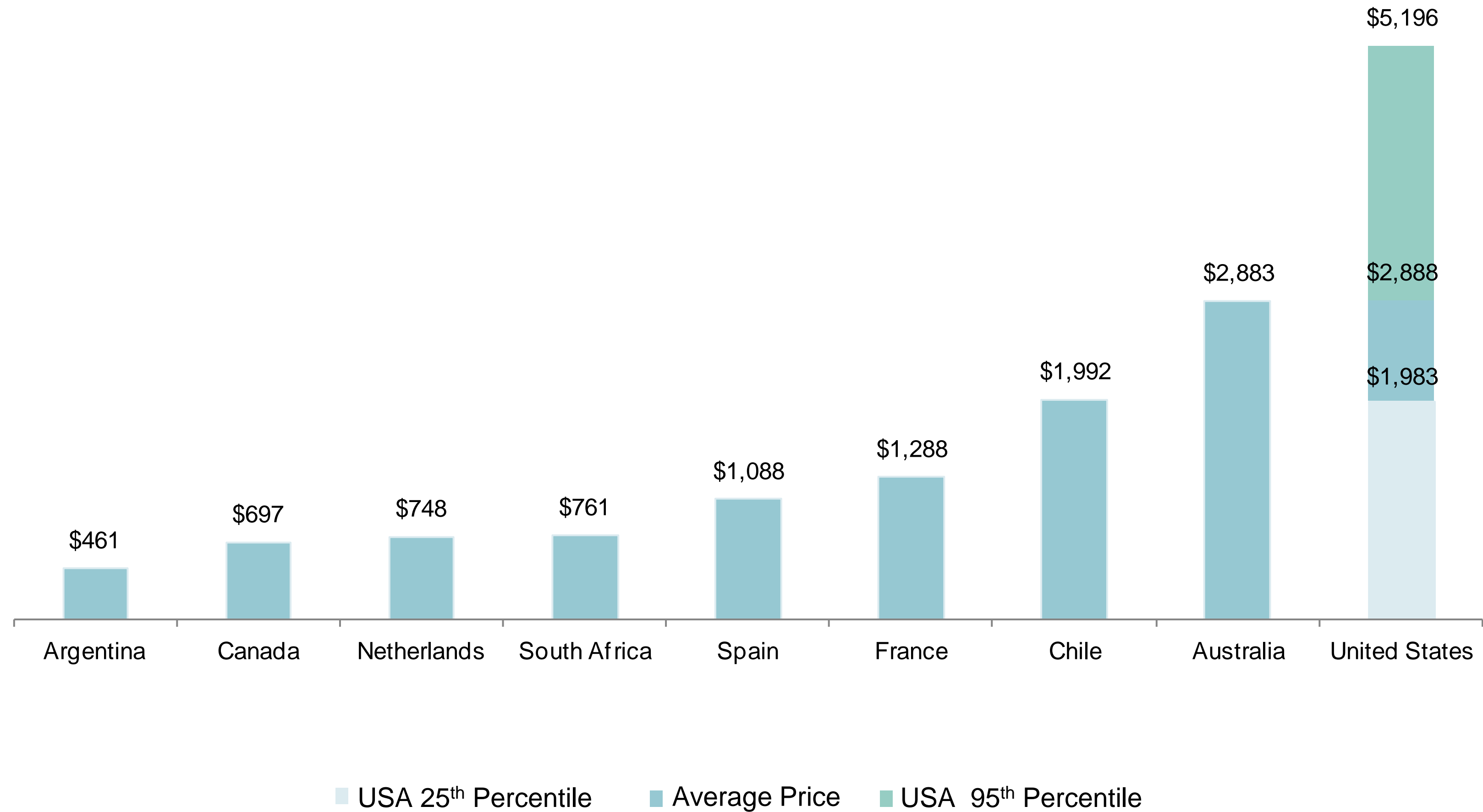
($ USD)

2012 Physician Fees: Appendectomy



($ USD)

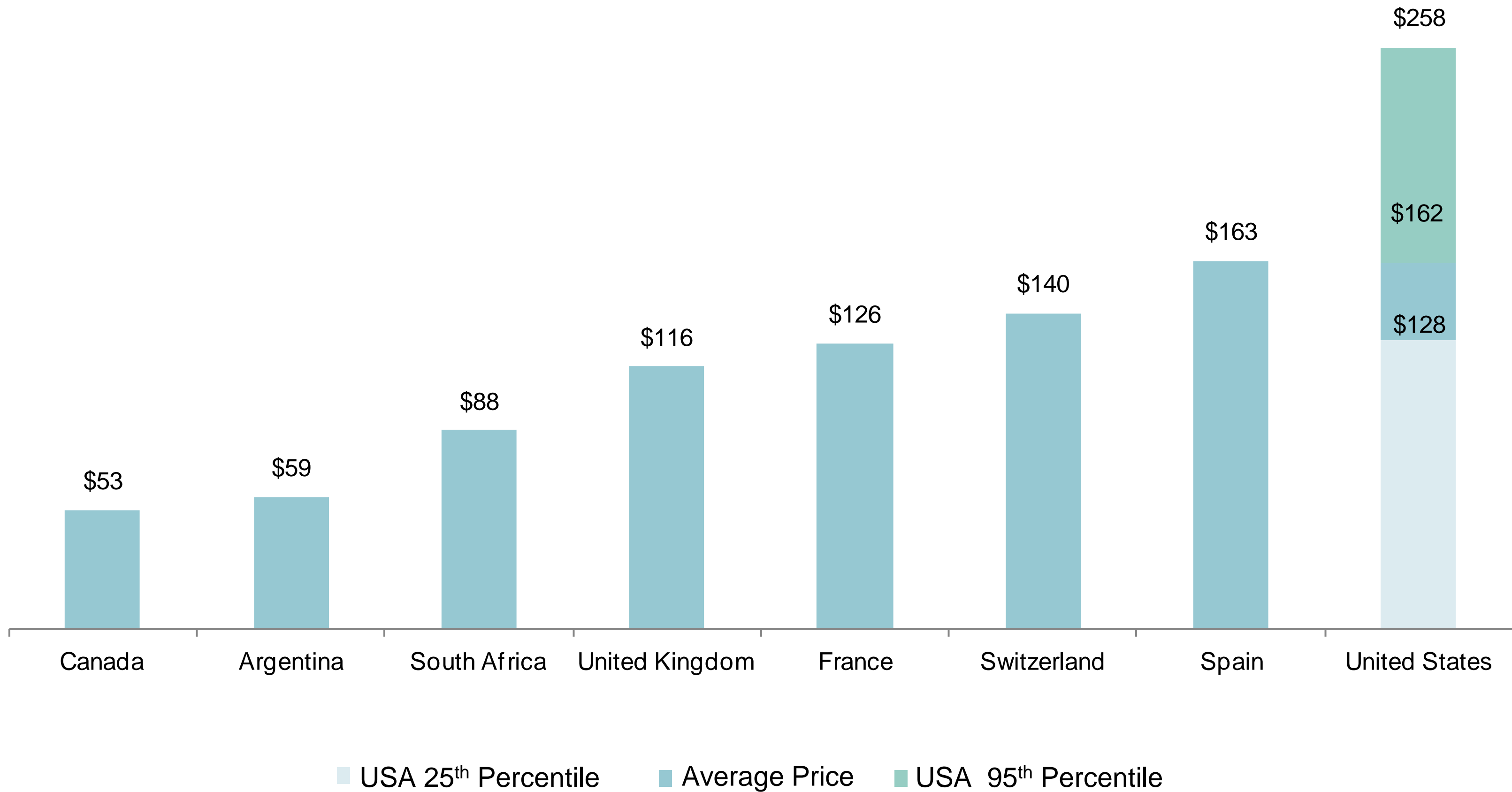
2012 Physician Fees: Hip Replacement



($ USD)

2012 Drugs: Celebrex

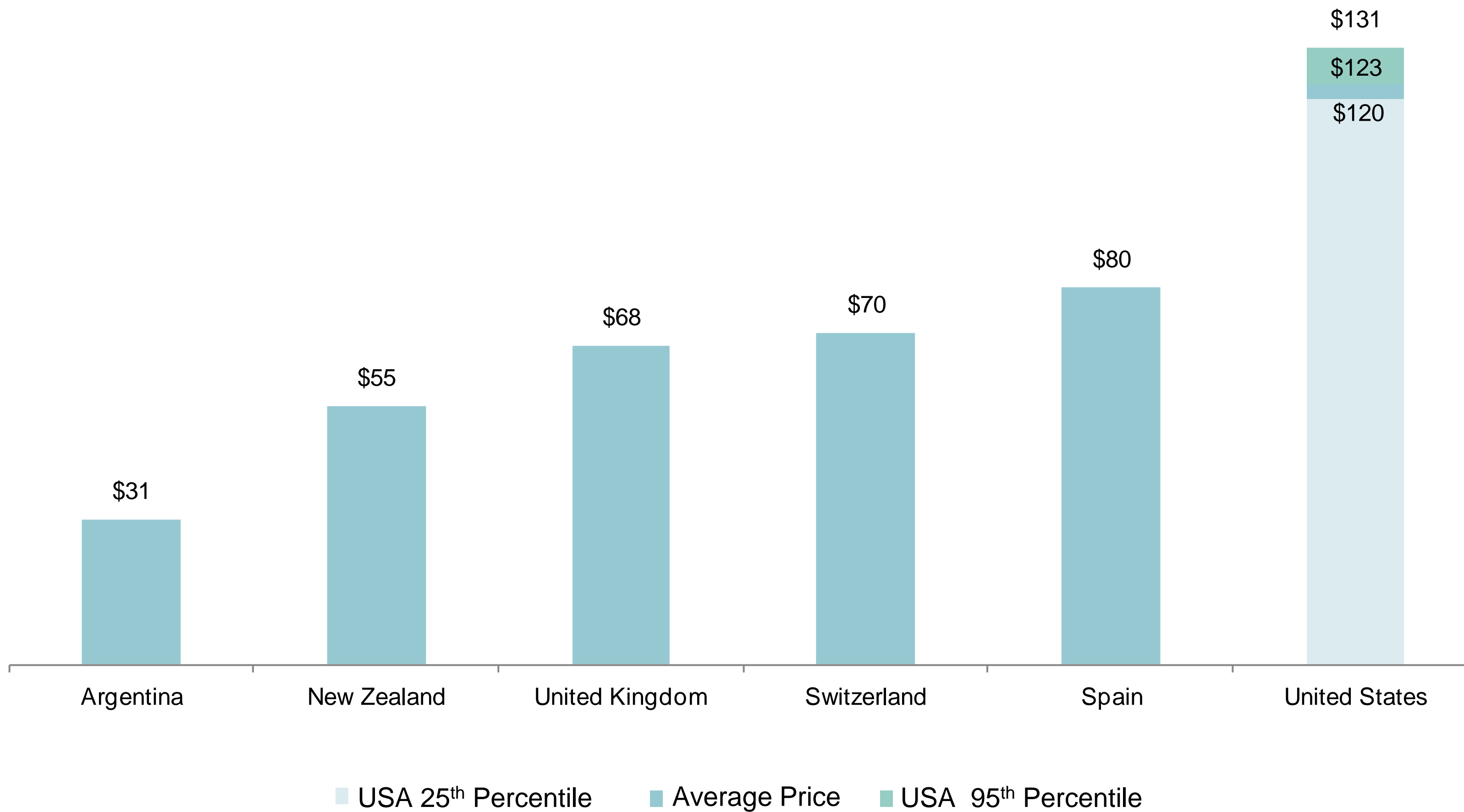
Celebrex is commonly prescribed for pain.



($ USD)

2012 Drugs: Vytorin

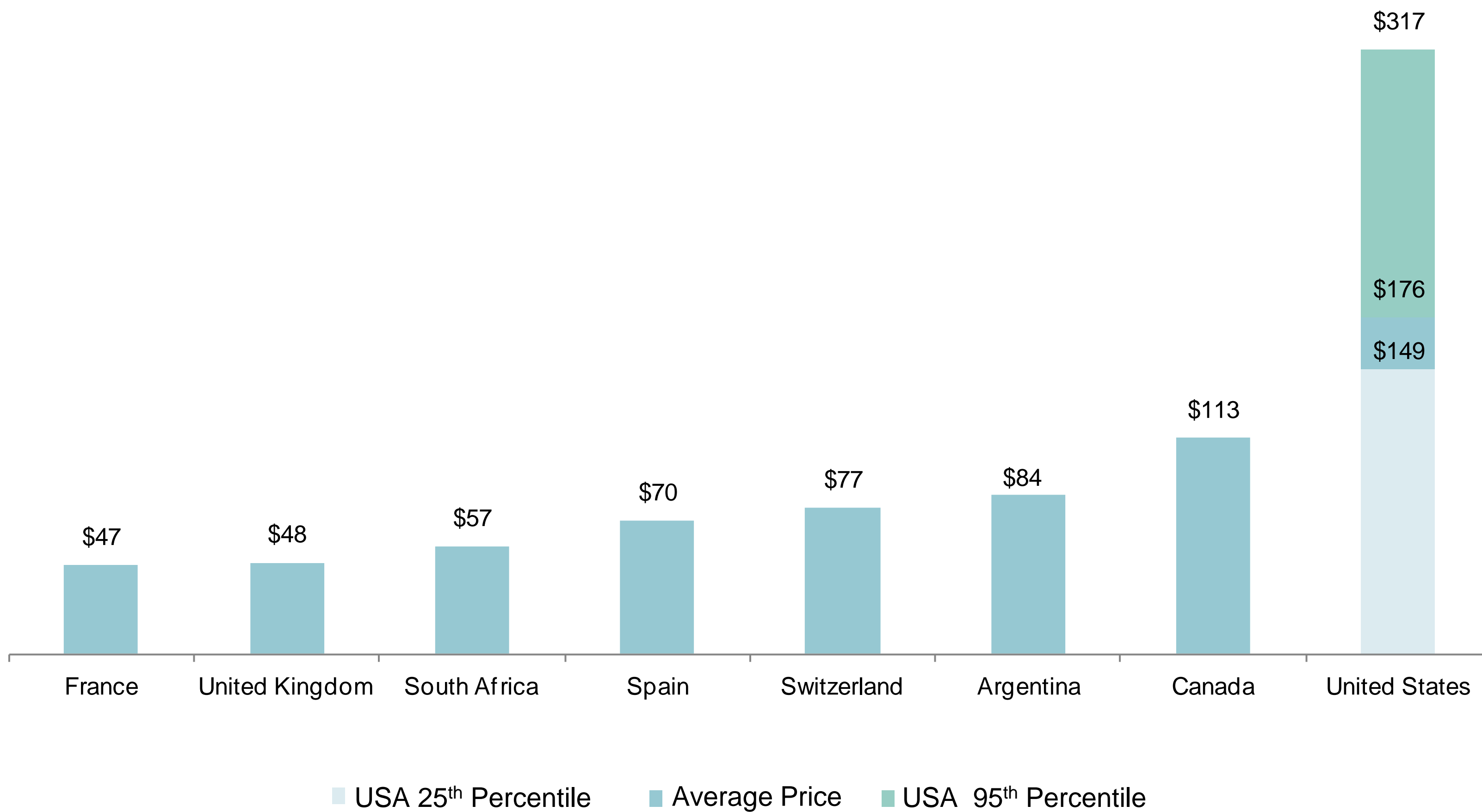
Vytorin is commonly prescribed for high cholesterol.



($ USD)

2012 Drugs: Cymbalta

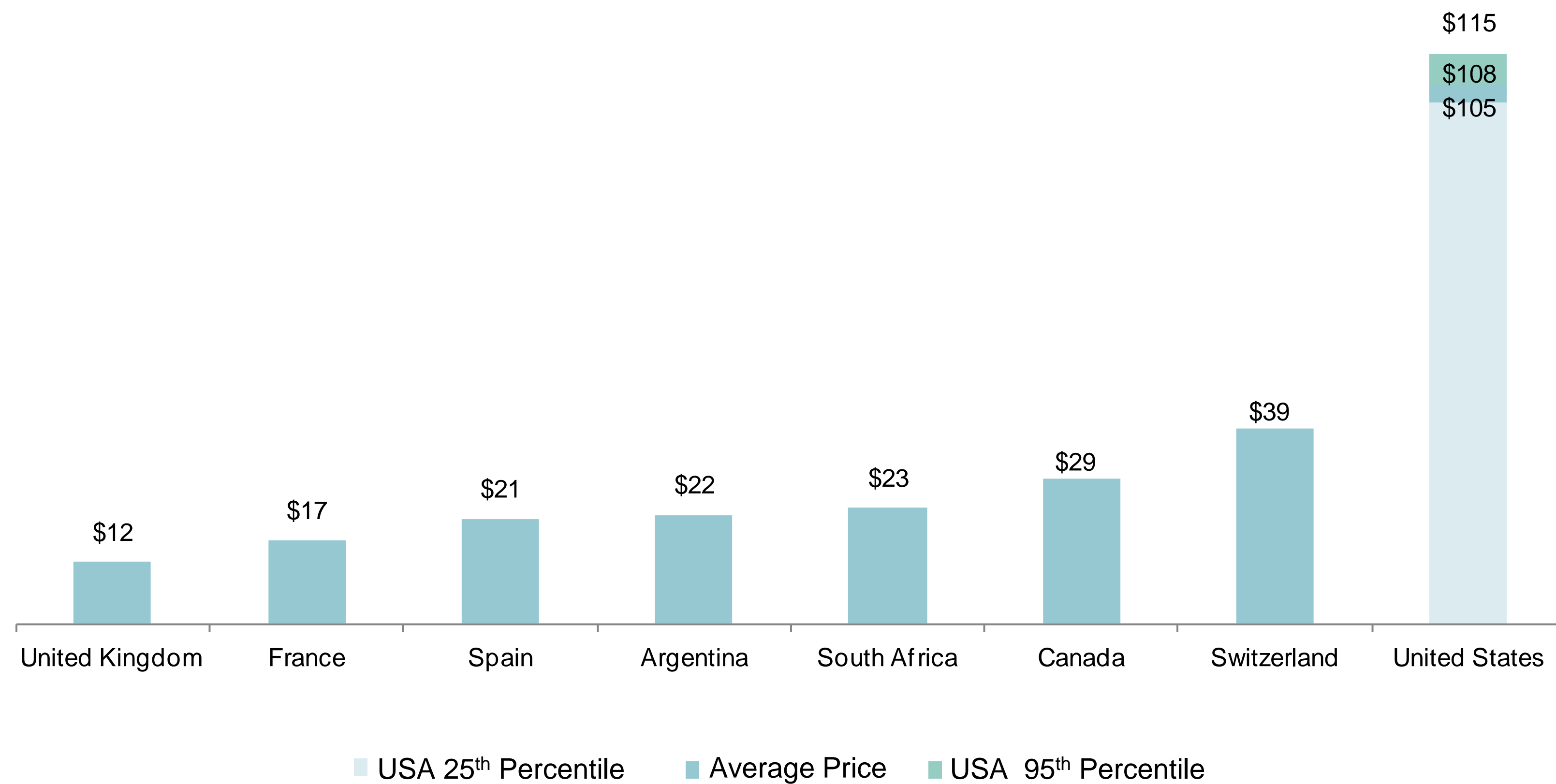
Cymbalta is commonly prescribed for depression, anxiety, and fibromyalgia.



($ USD)

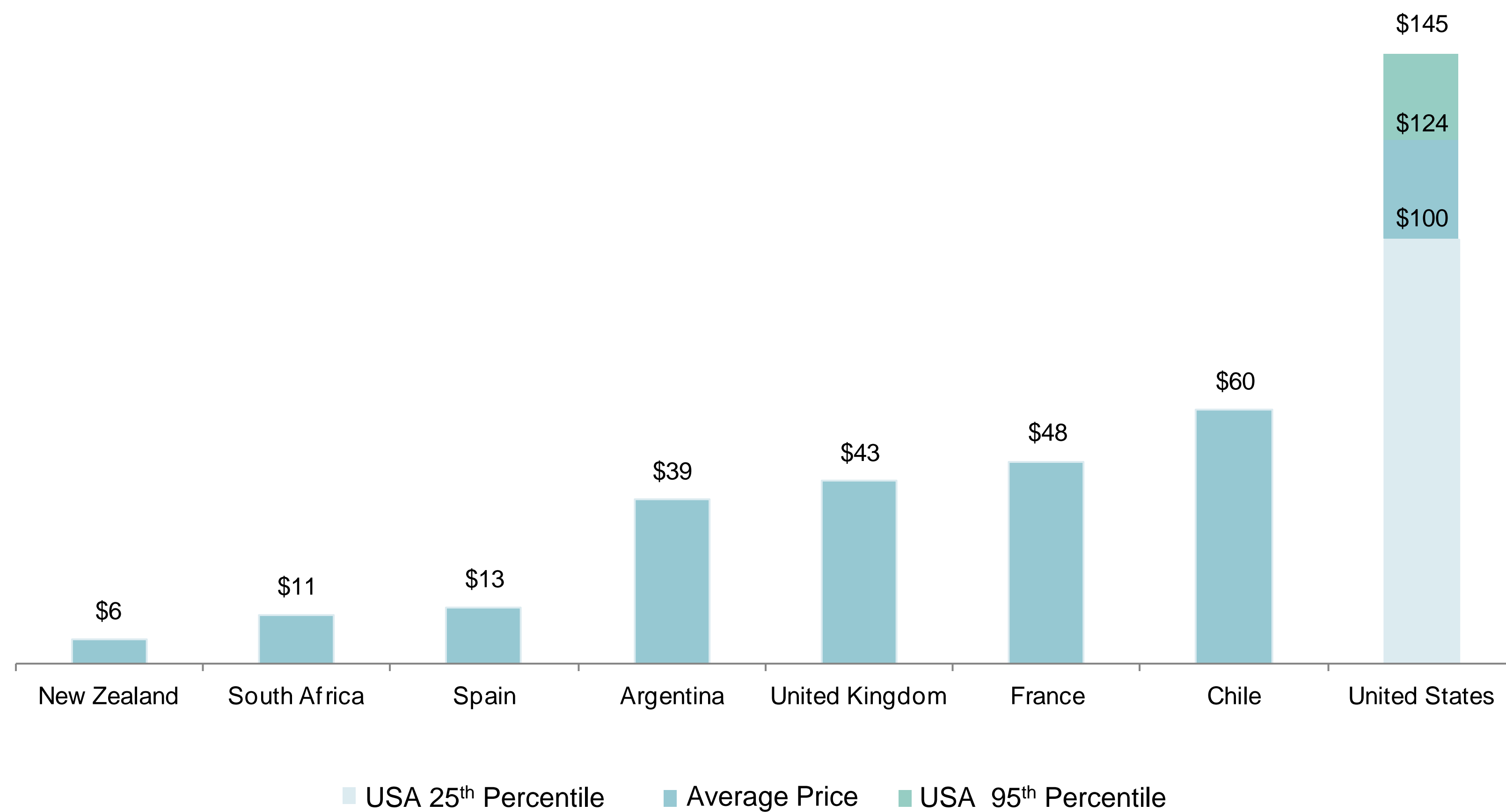
2012 Drugs: Nasonex

Nasonex is commonly prescribed for nasal allergies.



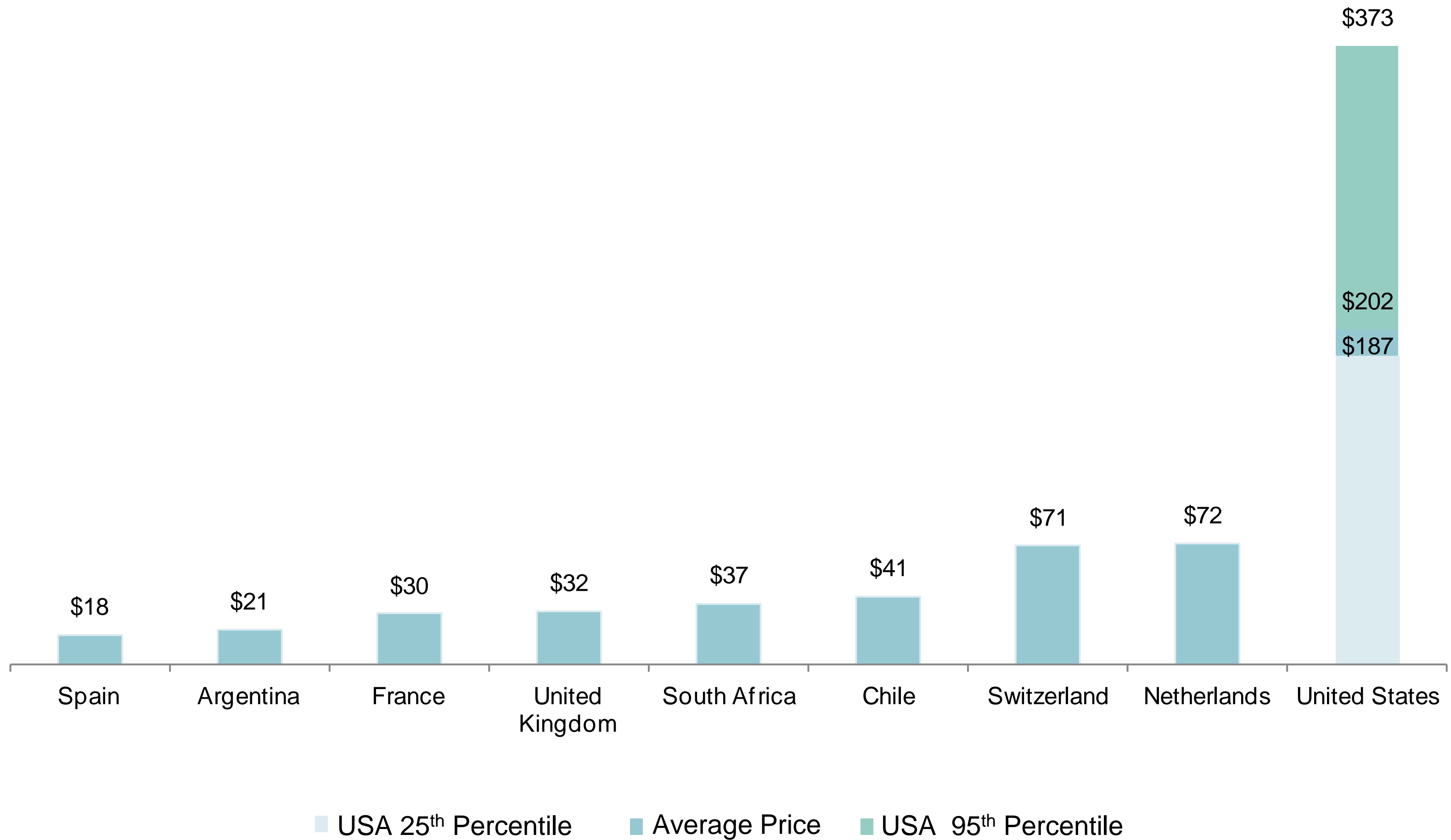
2012 Drugs: Lipitor

Lipitor is commonly prescribed for high cholesterol.

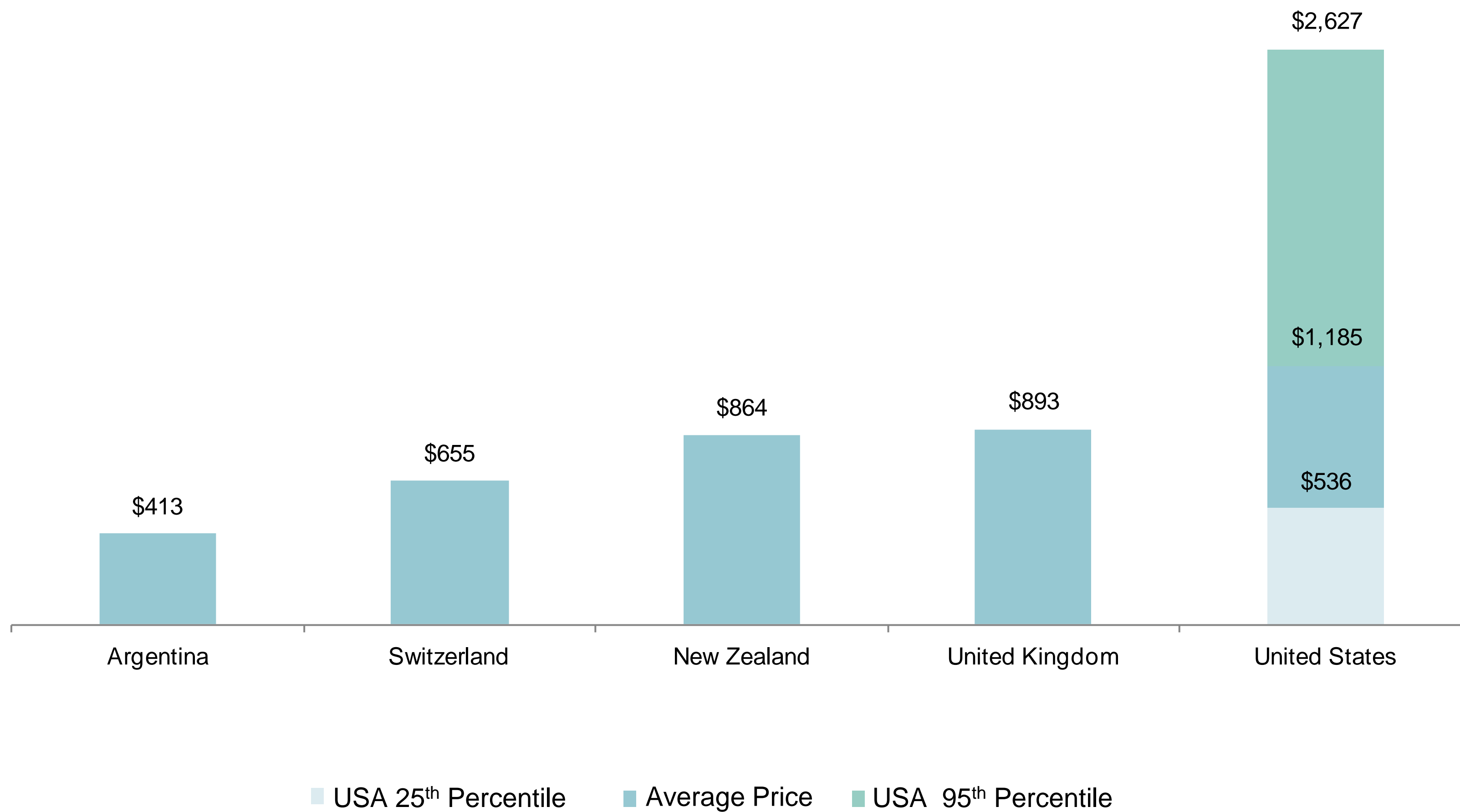


2012 Drugs: Nexium

Nexium is commonly prescribed for acid reflux.

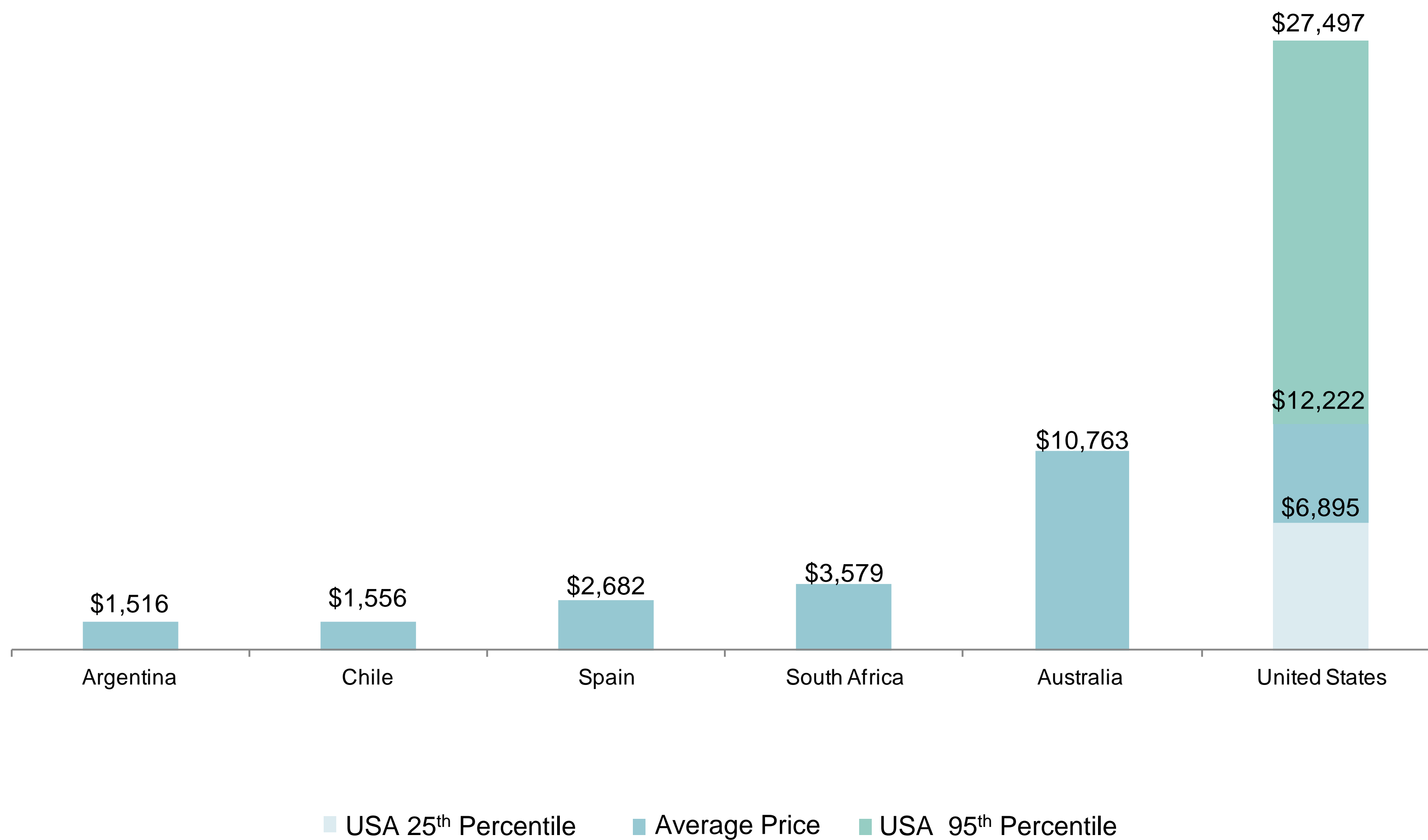


2012 Diagnostics: Colonoscopy

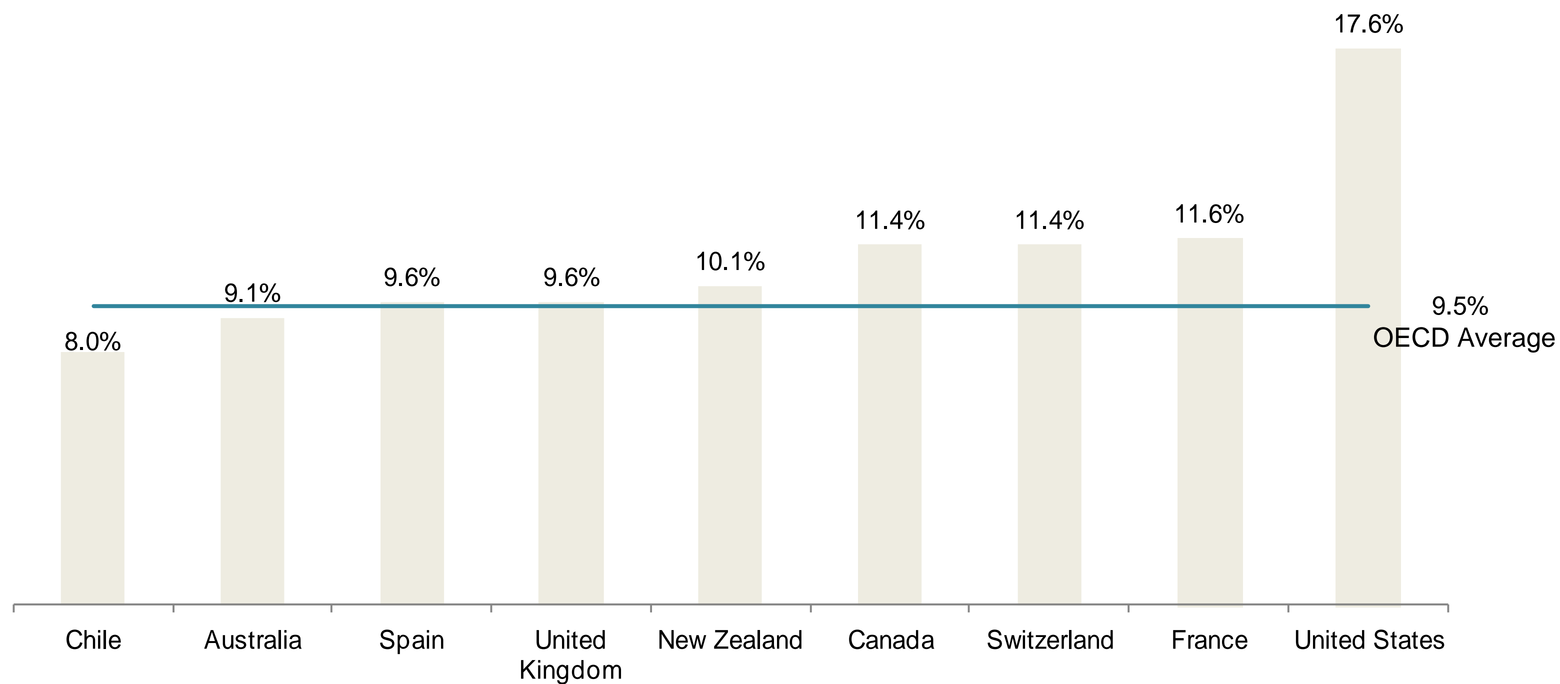


($ USD)

2012 Devices: Hip Prosthesis



2010 Health Spending as Percent of GDP



Source: OECD Health Spending 2012. Data represents 2010 or most recent year.

Country Sources and Notes

Argentina	Prices are a weighted average from the public system, the social security system, and a private health plan.
Australia	Prices are private sector prices paid by a private health plan.
Canada	Prices are public sector prices for the province of Nova Scotia.
Chile	Prices are private sector prices paid by a private health plan.
France	Prices are a blend of public and private system prices.
Netherlands	Prices are private sector prices paid by a private health plan, and incorporate the new DRG system implemented in 2012.
New Zealand	Prices are public sector prices based on the fee schedule for one large District Health Board, as well as other national tariff pricing lists.
South Africa	Prices are private sector prices paid by a private health plan.
Spain	Prices are private sector prices paid by a private health plan.
Switzerland	Prices are public sector prices.

Country Sources and Notes

United States

Prices are calculated from commercial claims data from the Truven (formerly Thomson Reuters) MarketScan Research databases. The MarketScan databases capture person-specific clinical utilization, expenditures, and enrollment from a selection of large employers, health plans, and government and public organizations. The annual medical databases include private sector health data from approximately 100 payers. Claims data was compiled by Deloitte Consulting LLP on behalf of Kaiser Permanente Health Plan. Any opinions or conclusions expressed herein regarding the data are not those of Deloitte Consulting LLP. Because a broad range of prices were available, the national 25th percentile (low), average, and 95th percentile were calculated. Prices represent allowed charges, which are the negotiated rates for which providers receive payment. Allowed charges include both patient cost sharing and health plan payment.

Cataract surgery price represents the price for outpatient procedures. The angioplasty and appendectomy prices reflect a blend of inpatient and outpatient prices based on relative utilization in each setting.

The patent for Lipitor expired on November 30, 2011. This has an impact on the drug's unit cost, and data show a rapid drop in volume and a gradual reduction in price for the branded version of this drug throughout 2012. The price in this report was calculated based on the same process as the other drug benchmarks, but incorporated an adjustment factor to reflect the impact on price of patent expiration. Prices may decline further over time, and the utilization of the drugs may also continue to decline as generic substitutes gain market share.

United Kingdom

Prices are public sector prices from the National Health Service (NHS) and the British National Formulary drug price listings.

List of Federation Member Plans

Argentina
Omint Sa De Servicios

Australia
Australian Health Service Alliance
Australian Health Insurance Association Limited
Australian Unity Health Limited
BUPA Australia Limited
GMHBA Limited
HBF Health Funds Inc
Hospitals Contribution Fund of Australia, Limited
Health-Partners
Medibank Private
Navy Health Limited
NIB Health Funds Limited
Police Health
RT Health Fund
Teachers' Federation Health Limited
Teachers' Union Health

Belgium
Medicover
Nationaal Verbond van Socialistiche Mutualiteiten
Union Nationale des Mutualities Libres (MLOZ)

Canada
Alberta Blue Cross Plan
Canassurance Hospital Service Association
Group Medical Services
Manitoba Blue Cross
Medavie Blue Cross
Pacific Blue Cross
Saskatchewan Blue Cross

Chile
Banmedica

China
BUPA China Representative Office

Denmark
Danmark Sygeforsikring
Danica Pension Forretningsudvikling
Forenede Gruppeliv A/S

Dominican Republic
Ars Humano

France
Malakoff Mederic

Germany
AXA Krankenversicherung AG
Munich Health

Greece
Interamerican Life Insurance Company

Hong Kong
AXA General Insurance Hong Kong Limited
BUPA (Asia) Limited

India
MAX BUPA Health Insurance Limited

Ireland
VHI Healthcare Limited

Italy
Unisalute

Mexico
AXA Seguros SA de CV

Netherlands
Achmea Health

New Zealand
Health Funds Association of New Zealand
Southern Cross Healthcare
Union Medical Benefits Society, Limited

Nigeria
Total Health Trust Limited

Poland
Signal Iduna Polska Tusa

Saudi Arabia
BUPA Middle East

South Africa
Board of Healthcare Funders of Southern Africa
Bonitas Medical Fund
Chartered Accountants (SA) Medical Aid Fund
Discovery Health Medical Scheme
La-Health Medical Scheme
Medihelp
Medscheme Holdings
Metropolitan Health Group
Polmed
Transmed

Spain
Compañia de Seguros Adeslas SA
Sanitas SA

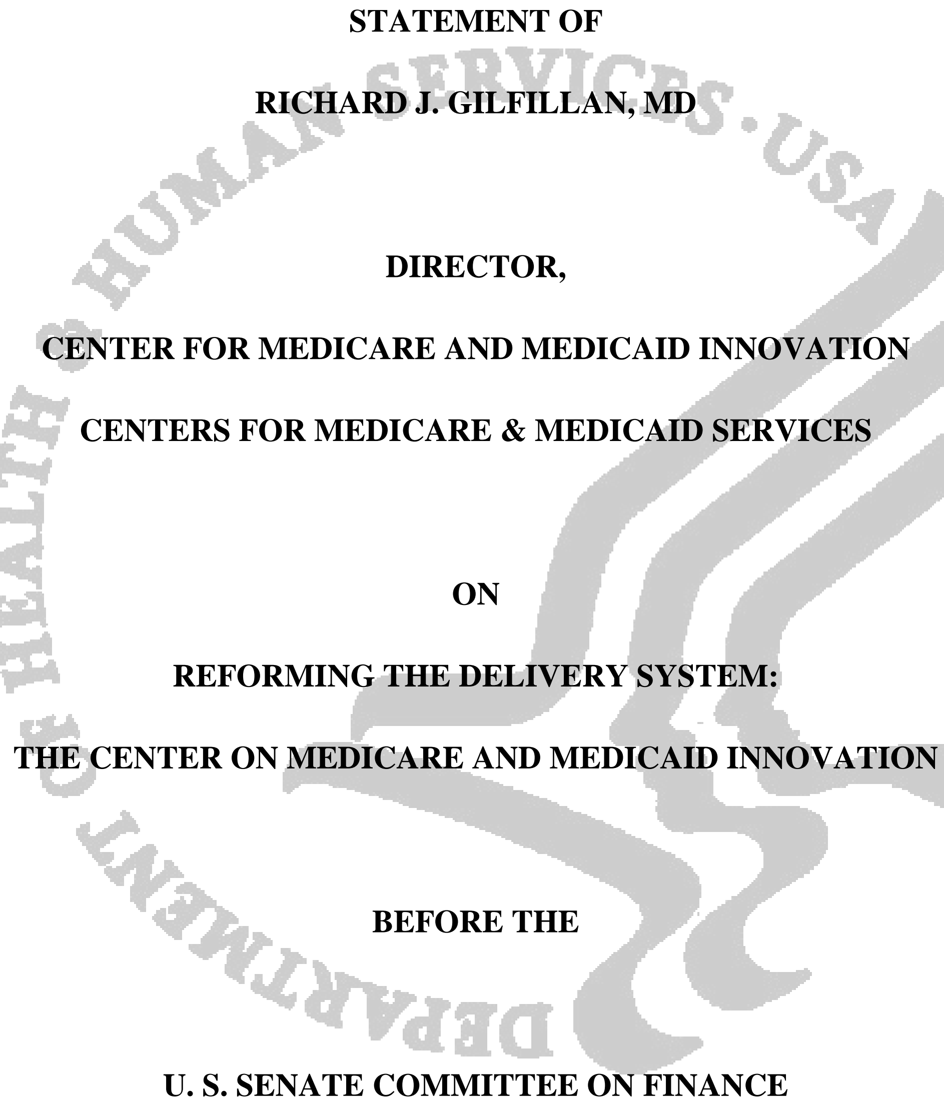
Switzerland
Helsana Versicherungen AG
Sanitas Krankenversicherung

Thailand
BUPA Health Insurance (Thailand) Limited

United Kingdom
Aria Assistance Group
AXA PPP Healthcare
BUPA
InterGlobal Insurance Company
Simplyhealth Group
Western Provident Association Limited
Westfield Contributory Health Scheme

USA
Aetna Inc
America's Health Insurance Plans
Blue Cross & Blue Shield Association
Emblem Foundation Health Plan
Kaiser Foundation Health Plan Inc
RW2 Enterprise
The Trizetto Group
Tufts Health Plan
UnitedHealth Group

Zimbabwe
Association of the Healthcare Funders of Zimbabwe
Cimas Medical Aid Society
The Medical Aid Society of Central Africa
Premier Service Medical Aid Society



STATEMENT OF

RICHARD J. GILFILLAN, MD

DIRECTOR,

CENTER FOR MEDICARE AND MEDICAID INNOVATION

CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

REFORMING THE DELIVERY SYSTEM:

THE CENTER ON MEDICARE AND MEDICAID INNOVATION

BEFORE THE

U. S. SENATE COMMITTEE ON FINANCE

MARCH 20, 2013

Senate Committee on Finance

Hearing on "Reforming the Delivery System:

The Center for Medicare and Medicaid Innovation"

March 20, 2013

Chairman Baucus, Ranking Member Hatch, and Members of the Committee, thank you for the opportunity to discuss our work at the Center for Medicare and Medicaid Innovation (the Innovation Center) at the Centers for Medicare & Medicaid Services (CMS). In the nearly three years since the Affordable Care Act became law, CMS has established the Innovation Center and initiated testing of numerous innovative payment and delivery models, under Innovation Center authority. The Innovation Center has also assumed administrative responsibility for a range of other pre-existing and separate statutory initiatives.

The Innovation Center has harnessed the energy and enthusiasm of a wide variety of innovators to help us identify models that can drive significant improvements in health care for enrollees in Medicare, Medicaid, and the State Children's Health Insurance Program (CHIP). What we have learned from our outreach – and it confirms my experience in the private sector – is that physicians and providers want and need reform that can allow them to provide sustainable, quality health care to their patients. We are currently working with more than 50,000 health care providers from every State in the country to test various models. Knowing that there is no one solution that will improve the health care system and reduce costs, the Innovation Center is casting a wide net through our broad portfolio to give options and opportunities to participate in testing models.

We are moving forward with a serious and rigorous process to monitor and evaluate the initiatives we have underway and to develop additional initiatives that build on these efforts. One of our goals is to create a solid business case for providers to engage in quality improvement. We have made significant progress in developing these models, and will continue to engage providers, payers, employers, States, and other stakeholders in our efforts. Medicare beneficiaries are already starting to enjoy better quality of care through innovative care delivery systems designed to improve their health outcomes and reduce costs. Affordable

Care Act reforms are contributing substantially to recent reductions in the growth rate of Medicare spending per beneficiary[1] without reducing benefits for beneficiaries. Growth in national health expenditures over the past three years was lower than any time over the last 50 years. Fraud recoveries have increased to a record $4.2 billion in 2012, and $14.9 billion over the last four years. Medicare beneficiaries have gained access to additional benefits, such as increased coverage of preventive services and lower cost-sharing for prescription drugs.

We are also observing a decrease in the rate of patients returning to the hospital after being discharged. After fluctuating between 18.5 percent and 19.5 percent for the past five years, the 30-day all cause readmission rate dropped to 17.8 percent in the final quarter of 2012. This decrease is an early sign that our payment and delivery reforms are having an impact.

Innovation Center Background

Congress created the Innovation Center to test "innovative payment and service delivery models to reduce program expenditures… while preserving or enhancing the quality of care" for those individuals who receive Medicare, Medicaid, or CHIP benefits. The Affordable Care Act appropriated $10 billion to support the Innovation Center's activities initiated from Fiscal Year (FY) 2011 to FY 2019.

Congress also defined – through both the Affordable Care Act and previous legislation – a number of specific CMS demonstrations. Some of these demonstrations test proposed improvements in care delivery and payment, such as the Independence at Home Initiative. The Innovation Center also assumed responsibility for several demonstrations that were initiated through CMS's former Office for Research Development and Information, which was brought into the Innovation Center.[2]

[1] ASPE Issue Brief: "Growth In Medicare Spending Per Beneficiary Continues To Hit Historic Lows" for full report please visit http://aspe.hhs.gov/health/reports/2013/medicarespendinggrowth/ib.cfm.

[2] The Innovation Center staff managed 23 statutorily-prescribed active demonstrations during the period between January 1, 2011 and October 31, 2012. Note that while the Innovation Center has administrative responsibility for these statutory demonstrations, they are not funded out of the Innovation Center's appropriation.

In support of the mission that Congress assigned to us, we organize the Center's work, and the organization structure,[3] around four main priorities: identifying and stimulating the development of innovative ideas; developing and testing new payments and service delivery models; evaluating results; and spreading best practices.

While the Center has new authorities and responsibilities, we execute these priorities within CMS's well-established governance and oversight processes. The Innovation Center works closely with other CMS Centers and Offices, through daily, weekly, biweekly, and monthly interactions and meetings. In particular, the Innovation Center works closely with the Center for Medicaid and CHIP Services on initiatives involving Medicaid or CHIP beneficiaries, with the Center for Medicare on initiatives involving Medicare beneficiaries, and with the Medicare-Medicaid Coordination Office on initiatives involving beneficiaries enrolled in both Medicare and Medicaid.

Identifying and Stimulating the Development and Testing of Innovative Ideas

During the development of models, the Innovation Center receives ideas from stakeholders, and consults with clinical and analytical experts, as well as with representatives of relevant Federal agencies. The Innovation Center actively engages innovators through its website, social media outreach, and an email listserv that reaches an audience of over 30,000 people across the country who are interested in innovations in health care delivery and payment. Since its formation, the Innovation Center has held numerous regional meetings, listening sessions, and open-door forums to engage thousands of innovators from around the country. In addition, stakeholders have shared more than 500 ideas for improving health care through the Share Your Ideas section of the Innovation Center's website.[4]

For all models, the Innovation Center selects participating organizations through an open process. The process follows established protocols to ensure that it is fair and transparent,

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[3] The Innovation Center's organizational structure is available at http://innovation.cms.gov/about/Our-Team/index.html.

[4] http://innovation.cms.gov/Share-Your-Ideas/Submit/index.html.

provides opportunities for potential partners to ask questions regarding the Innovation Center's expectations, and relies on multi-stakeholder expertise to select the most qualified partners.

Current Innovation Center Models

The Innovation Center is currently responsible for numerous initiatives that test new payment or care delivery systems following the business and experimental processes described above.[5] Major examples of the Innovation Center's initiatives include:

- The *Pioneer Accountable Care Organization (ACO) and Advance Payment ACO models*, which aim to align incentives for organizations to promote higher quality care and better health outcomes for the population served and greater accountability for the total cost of care;
- The *Bundled Payments for Care Improvement Initiative*, which is a series of four models that will realign incentives for hospitals and post-acute care providers to promote quality and efficiency;
- The *Comprehensive Primary Care Initiative*, which provides support to transform primary care practices;
- The *Strong Start for Mothers and Newborns Initiative*, which is an effort to test and evaluate enhanced prenatal care interventions for women enrolled in Medicaid or CHIP who are at risk for having a preterm birth;
- The *State Innovation Model*, which makes awards to States to design and test multi-payer payment and delivery models that seek to deliver high-quality health care and improve health system performance; and
- The *Health Care Innovation Awards*, which funds projects in communities across the Nation that aim to deliver better health, improved care, and lower costs to people enrolled in Medicare, Medicaid, and CHIP.

Each model has been developed to create a business case for quality improvement, relying on innovation to reduce spending while improving patient experience and health outcomes, and rewarding quality and population health management rather than greater volume of care.

[5] A full list of the Innovation Center's initiatives is available at http://innovation.cms.gov/.

Accountable Care Organizations (ACOs)

ACOs are one of the Affordable Care Act's key reforms to improve the delivery of care. ACOs are groups of doctors and other health care providers that have agreed to work together to treat beneficiaries and better coordinate their care across care settings. They share – with Medicare – a portion of savings generated from lowering the growth in health care costs while furnishing high quality care including providing patient-centered care.

Working in concert with the Medicare Shared Savings Program (Shared Savings Program), which is a permanent part of the Medicare program, the Innovation Center is testing two alternative ACO models—the Pioneer and Advance Payment model ACOs—both of which can inform future changes to the Shared Savings Program. The Innovation Center designed the Pioneer ACO model for health care providers that have experience coordinating care for patients across care settings. This model tests alternative payment models that include increasing levels of financial accountability. Thirty-two organizations are testing the Pioneer ACO model.

The Advance Payment ACO model examines whether and how pre-paying a portion of future shared savings could increase participation in the Shared Savings Program from entities such as physician-owned and rural providers with less capital. Through this ACO model, selected participants receive upfront and monthly payments, which they can use to make important investments in their care coordination infrastructure. It is our expectation that the assistance the Advanced Payment model provides to smaller and rural practices will result in expanding access to this coordinated care effort to more fee-for-service Medicare beneficiaries. Thirty-five ACOs are participating in this model.

In just over a year, more than 250 ACOs in 47 States and territories have formed and are working to improve the care experience for more than four million Medicare fee-for-service beneficiaries nationwide, which represents approximately eight percent of all Medicare beneficiaries. That number will grow over time as existing ACOs choose to add providers and more organizations are approved for participation in the Medicare Shared Savings Program.

Bundled Payments for Care Improvement Initiative

Traditionally, Medicare makes separate payments to providers for each of the individual services they furnish to beneficiaries during a single illness or course of treatment. This approach can result in fragmented care and a lack of coordination across health care settings. Bundling payments to multiple providers can better align incentives to those providers – hospitals, post-acute care providers, physicians, and other practitioners– leading them to work closely together to redesign care and better coordinate across all specialties and settings.

The Bundled Payments for Care Improvement Initiative is composed of four broadly-defined models of care, which link payments for multiple services beneficiaries receive during an episode of care. Over the course of the three-year initiative, CMS will work with hundreds of organizations to assess whether the models being tested result in enhanced quality of care and lower costs to Medicare. In January 2013, the Innovation Center announced the participants in Model 1, which tests bundled payments for acute care hospital stays, as well as the participants in Phase One of Models 2 through 4 of the Bundled Payments for Care Improvement Initiative. Phase One is the initial period of the initiative where the participants and CMS prepare for implementation and assumption of financial risk by sharing data and information. Phase Two will begin this summer.

Comprehensive Primary Care

The Innovation Center is also supporting primary care providers interested in transforming their practice. Approximately 500 primary care practices[6] in seven markets are participating in the Comprehensive Primary Care initiative, which is a multi-payer model testing the effectiveness of enhanced payments to improve care coordination for people enrolled in Medicare and Medicaid. We consulted extensively with other payers to design a model that would be suitable for adoption by Medicare, commercial, and Medicaid payers.

Under the Comprehensive Primary Care initiative, Medicare will pay primary care practices a care management fee to support enhanced, coordinated services. Simultaneously, participating

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[6] For a full list of participating practices please visit https://data.cms.gov/Government/CPC-Initiative-Participating-Primary-Care-Practice/mw5h-fu5i.

commercial, State, and other Federal insurance plans are also offering an enhanced payment to primary care practices that provide high-quality primary care. In order to receive the new care management fee from Medicare and other payers, primary care practices must agree to provide enhanced services for their patients, deliver preventive care, coordinate care with patients' other health care providers, engage patients and caregivers in managing their own care, and provide individualized, enhanced care for patients living with multiple chronic diseases and higher needs. To simplify the model for practitioners, and to maximize its impact, CMS and other payers used a coordinated approach to transform how primary care is practiced and financially supported. CMS and other payers also agreed to align quality measures in the model.

Strong Start for Mothers and Newborns

The Strong Start for Mothers and Newborns initiative, launched in 2012, is a two-part strategy to reduce preterm births and improve outcomes for newborns and pregnant women. The first is a public-private partnership and awareness campaign to reduce the rate of early elective deliveries prior to 39 weeks for all populations. Avoiding elective deliveries prior to 39 weeks has been a medical best practice recommended by the American Congress of Obstetricians and Gynecologists (ACOG) for more than 20 years but remains a persistent problem. CMS partnered with the ACOG, the March of Dimes, State and local governments, and the private sector to focus on increasing public awareness of this issue. The other component of the Strong Start Initiative is a funding opportunity to test the effectiveness of specific enhanced prenatal care approaches to reduce the frequency of premature births among high-risk pregnant women enrolled in Medicaid or CHIP.

In February 2013, we announced the recipients of 27 Strong Start for Mothers and Newborns awards with a total of up to $41.4 million made available to States, providers, academic institutions, and others to test new ways to prevent significant, long-term health problems for high-risk pregnant women and newborns enrolled in Medicaid or CHIP. The Strong Start awardees are located in 32 States, the District of Columbia, and Puerto Rico, and will serve more than 80,000 women enrolled in Medicaid or CHIP over the three intervention years. The grants will support enhanced prenatal care through group visits, at birth centers, and at maternity medical homes. These approaches expand access to care, improve care coordination, and

provide psychosocial support to pregnant women. Strong Start awardees will be serving women in the areas with the highest preterm birth rates in the country, including areas that are among the top ten prematurity and infant mortality counties according the Centers for Disease Control and Prevention. The Innovation Center will administer these awards through cooperative agreements over four years.

State Innovation Model

The State Innovation Model initiative was developed for States that are prepared for or committed to planning, designing, and testing new payment and service delivery models in the context of larger health system transformation. The goal is to create multi-payer models with a broad mission to improve community health and reduce long-term health risks for beneficiaries of Medicare, Medicaid, and CHIP, and lower costs in these programs.

The Innovation Center recently announced 25 States are participating in the first round of funding. Six States have received model-testing awards that support the implementation of their State's Health Care Innovation Plan. The Plan is a proposal that describes a State's strategy to use all of the levers available to it to transform its health care delivery system through multi-payer payment reform and other State-led initiatives. Three States are receiving pre-testing awards that will allow them to continue work on their Health Care Innovation Plans, and sixteen States are receiving model design awards to develop Health Care Innovation Plans. We expect to award additional model-testing awards in the future and expect that States that were given design awards will apply for the next round of model-testing awards.

Health Care Innovation Awards

The Health Care Innovation Awards were awarded to 107 recipients who are testing innovative care delivery models that aim to improve outcomes and reduce costs. Awardees were chosen for their innovative solutions to the health care challenges facing their communities and for their focus on creating a well-trained health care workforce that is equipped to meet the Nation's needs in our 21st-century health system. The initiative supports innovators who can rapidly deploy care improvement models (within six months of award) through new ventures or expansion of existing efforts to new populations of patients, in conjunction (where possible) with

other public and private sector partners. Funding for these projects is for three years. The projects are located in urban and rural areas, all 50 States, the District of Columbia, and Puerto Rico.

Some examples of the projects include the Prosser Washington Community Paramedics Program in Washington State, which received an award for a program through which physicians can send a community paramedic to visit a patient of concern, providing in-home medical monitoring, follow-ups, basic lab work, and patient education. By expanding the role of the emergency medical services, community paramedics can increase access to primary and preventive care, provide wellness interventions, decrease emergency room utilization, and improve outcomes.

Another awardee is the Delta Dental Plan of South Dakota's project, "Improving the care and oral health of American Indian mothers and young children and American Indian people with diabetes on South Dakota reservations." Delta Dental Plan, which covers over thirty-thousand isolated, low-income, and underserved Medicaid beneficiaries and other American Indians on reservations throughout South Dakota, aims to improve oral health and health care for American Indian mothers, their young children, and American Indian people with diabetes. Providing preventive care will help avoid and arrest oral and dental diseases, repair damage, prevent recurrence, and ultimately, reduce the need for surgical care.

Other Innovation Center Models

Other Innovation Center initiatives include the *Independence at Home Demonstration*,[7] created by the Affordable Care Act, which uses home-based primary care teams designed to improve health outcomes and reduce expenditures for Medicare beneficiaries with multiple chronic conditions. Under the Independence at Home Demonstration, selected primary care practices will provide home-based primary care to targeted chronically ill beneficiaries for a three-year period. Participating practices will make in-home visits tailored to an individual patient's needs and preferences with the goal of keeping them from being hospitalized.

[7] The Independence at Home Demonstration is funded and authorized by § 3024 of the Affordable Care Act – not § 3021, which established the Innovation Center.

Additionally, the Innovation Center and the Health Resources and Services Administration (HRSA) jointly manage the *Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration*. Approximately 500 FQHCs are testing whether achieving certification as a medical home can improve care, health, and reduce costs. In addition to the Innovation Center's payments of per beneficiary amounts to support the FQHC's investment in primary care, HRSA is providing technical assistance to the FQHCs.

Another initiative is the *Partnership for Patients*, which is a public-private partnership to support physicians, nurses, and other clinicians in reducing hospital-acquired conditions and improving transitions in care. It will test the effect of multiple strategies to improve patient safety in hospitals, including reducing preventable hospital-acquired conditions and reducing 30-day readmissions. Part of the Partnership for Patients is the *Community-based Care Transitions Program*, an initiative in which 102 participants are working with local hospitals and other service providers to support Medicare patients who are at increased risk of being readmitted to the hospital while transitioning from care settings.[8] The Community-based Care Transitions Program will provide care transition services to over 700,000 Medicare beneficiaries in 40 States across the country.

Other initiatives being tested by the Innovation Center are intended to improve care coordination for beneficiaries with end-stage renal disease (ESRD), support hospitals for the cost of providing clinical training to advanced practice registered nursing students,[9] and determine whether Medicaid can support higher quality care at a lower total cost by reimbursing private psychiatric hospitals for certain psychiatric services for which Medicaid reimbursement has historically been unavailable.[10] The Innovation Center also collaborates with the Medicare-Medicaid Coordination Office to improve the quality of care available to and better coordinate benefits and services for the Medicare-Medicaid enrollee population. This latter category includes initiatives

[8] The Community-based Care Transitions Program is funded and authorized by § 3026 of the Affordable Care Act – not § 3021, which established the Innovation Center.
[9] The Graduate Nurse Education Demonstration is funded and authorized by § 5509 of the Affordable Care Act.
[10] The Medicaid Emergency Psychiatric Demonstration is funded and authorized by § 2707 of the Affordable Care Act.

focused on improving financial alignment between Medicare and Medicaid and reducing avoidable hospitalizations among nursing facility residents.

Evaluating Results and Actively Spreading Best Practices

Congress provided the Secretary of Health and Human Services (HHS) with the authority to expand the scope and duration of a model being tested through rulemaking, including the option of expanding on a nationwide basis. For the Secretary to exercise this authority, a model must reduce net spending (as certified by the CMS Chief Actuary) without reducing the quality of care. No model may deny or limit the coverage or provision of Medicare, Medicaid, or CHIP benefits.

The law also requires that models tested by the Innovation Center shall be modified or terminated, unless the Secretary determines (and the CMS Chief Actuary certifies, with respect to spending) after testing has begun that the model is expected to improve the quality of care without increasing spending, reduce spending without reducing the quality of care, or improve the quality of care and reduce spending. The Innovation Center, working in concert with the Office of the Actuary, continuously monitors progress and results in order to quickly identify successful and unsuccessful models and take necessary action.

To assess the success of initiatives, the Innovation Center has assembled the Rapid Cycle Evaluation Group, responsible for evaluating the impact of each payment and service delivery model on the cost and quality of care, and on health outcomes. The Innovation Center, when considering a model for testing, engages staff from the Rapid Cycle Evaluation Group and the Office of the Actuary. Early in the process of implementation, evaluation staff considers advanced statistical methods, carefully defines and selects comparison groups, and applies conservative evidence thresholds to assure that programs deemed successful represent high-value investments of taxpayer dollars.

Establishing effective metrics at the outset of each model is critical to defining success. The Innovation Center selects measures for those that are appropriate for each model. Innovation Center evaluators collaborate with other CMS components to ensure that the metrics we use are

consistent across our programs as appropriate, and that we can thoughtfully compare the results of different models.

The Rapid Cycle Evaluation Group assesses each model's impact regularly and frequently to identify successful programs as quickly as possible. The Rapid Cycle Evaluation Group also provides ongoing feedback to participating entities to support continuous quality improvement on a quarterly basis. To determine the cost impact of the model, the Office of the Actuary monitors Innovation Center initiatives, and, once testing begins, will use data from the evaluation and monitoring as well as other available sources to certify results. The testing period for most models is typically three to five years, but in some cases it may be clear from the data within one or two years whether a model should be recommended for testing more broadly in Medicare, Medicaid, or CHIP, or should be terminated or modified.

The Innovation Center's work reflects a core belief that effective health care system reform requires continuous learning and sharing of best practices. Using data from the Rapid Cycle Evaluation Group, the Innovation Center organizes learning collaboratives among model participants to share effective approaches and disseminate best practices. This close collaboration will help ensure that best practices are disseminated rapidly, and aims to generate a more cooperative community of providers working together to improve the quality of care.

Looking Forward

The Innovation Center initiatives complement other reforms made by the Affordable Care Act. Thanks to the law, the Innovation Center is moving toward a system that provides better care and better health, and through these improvements, reduced cost. We look forward to advancing models and demonstrations that will provide the results our health care system needs.

The McGraw-Hill Companies

Press Release

J.D. Power and Associates Reports:
Kaiser Foundation Health Plan Ranks Highest in Member Satisfaction among Health Plans in the South Atlantic Region for a Second Consecutive Year

WESTLAKE VILLAGE, Calif.: 17 March 2011 — Kaiser Foundation Health Plan ranks highest in member satisfaction with health plans in the South Atlantic region for a second consecutive year, according to the J.D. Power and Associates 2011 U.S. Member Health Insurance Plan Study^{SM} released today.

Now in its fifth year, the study measures member satisfaction among 137 health plans in 17 regions throughout the U.S. by examining seven key factors: coverage and benefits; provider choice; information and communication; claims processing; statements; customer service; and approval processes.

Kaiser Foundation Health Plan achieves a score of 747 on a 1,000-point scale and performs well in the South Atlantic region in four of the seven factors: coverage and benefits; information and communication; statements; and customer service. Following Kaiser Foundation Health Plan in the regional rankings are BlueCross BlueShield of North Carolina (714) and BlueCross BlueShield of Georgia (704).

In 2011, overall member satisfaction is at the lowest point since the study's inception in 2007, averaging 696, compared with 701 in 2010. Member satisfaction with coverage and benefits has decreased slightly, with considerable declines occurring in satisfaction with information and communication; claims processing; and statements.

"Information and communication remains the factor with lowest satisfaction among all plans, possibly reflecting the increasing complexity of health benefits," said Richard Millard, senior director of the healthcare practice at J.D. Power and Associates. "Because members are increasingly concerned about the uncertainties surrounding cost and coverage, plans that focus on delivering useful information to manage these changes tend to earn higher satisfaction scores."

The average satisfaction index score in the South Atlantic region is 700—four points higher than the 17-region national average. While overall satisfaction among health plan members has declined significantly in four of the 17 regions, performance in the South Atlantic region has improved slightly in 2011, compared with 2010.

The 2011 U.S. Member Health Insurance Plan Study is based on responses from more than 34,000 members of commercial health plans. There were 2,030 members in the South Atlantic region, which includes Georgia, North Carolina and South Carolina. The study was fielded in December 2010 and January 2011. For more comprehensive health plan rankings for all 17 U.S. regions, please visit www.jdpower.com.

About J.D. Power and Associates
Headquartered in Westlake Village, Calif., J.D. Power and Associates is a global marketing information services company providing forecasting, performance improvement, social media and customer satisfaction insights and solutions. The company's quality and satisfaction measurements are based on responses from millions of consumers annually. For more information on car reviews and ratings, car insurance, health insurance, cell phone

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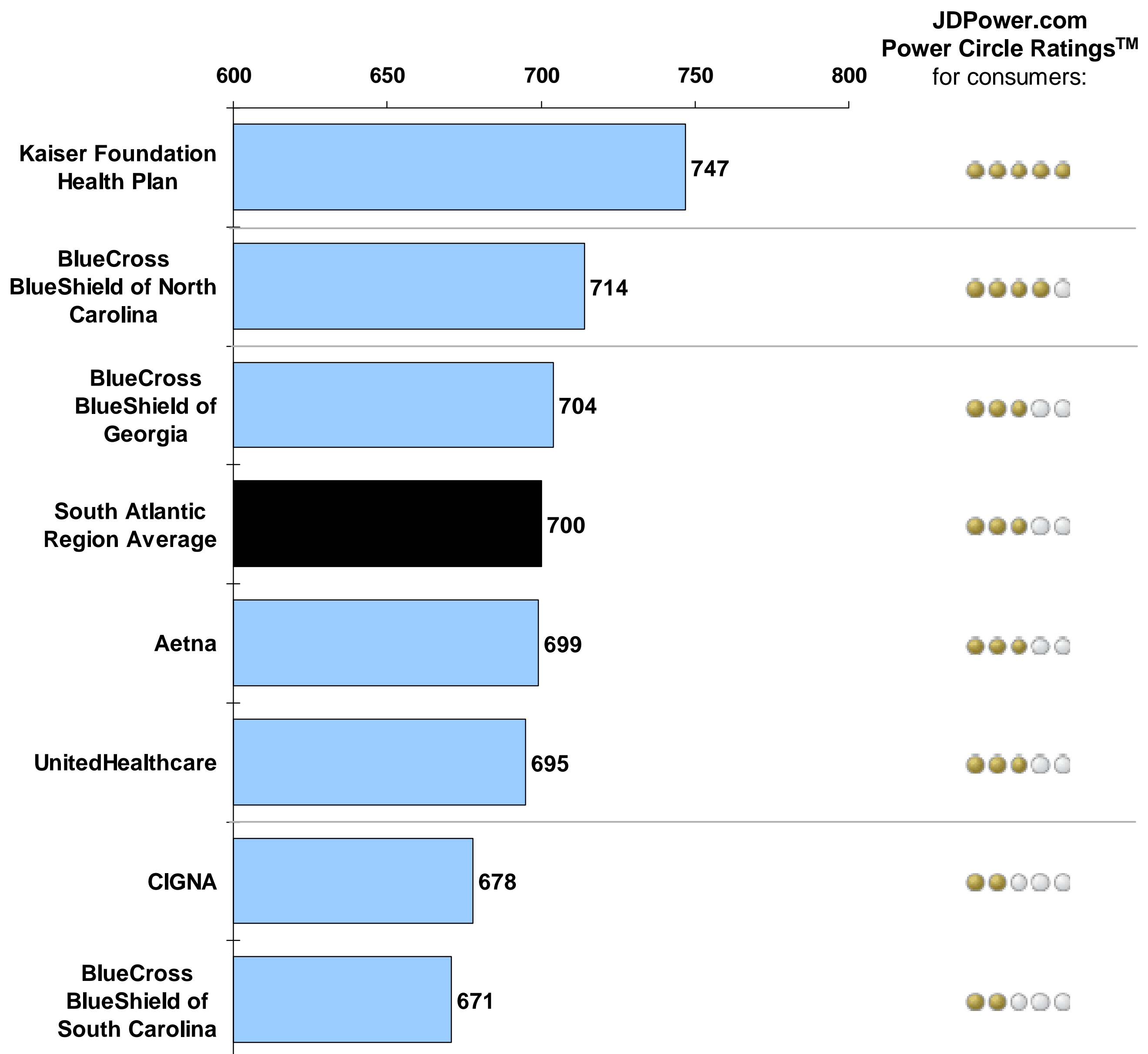
# # #

NOTE: One chart follows.

J.D. Power and Associates
2011 U.S. Member Health Insurance Plan Study^SM

Member Satisfaction Index Ranking
South Atlantic Region
(Based on a 1,000-point scale)



Included in the study but not ranked due to small sample size is Humana.

Included in the South Atlantic Region are: Georgia, North Carolina and South Carolina.

Source: J.D. Power and Associates 2011 U.S. Member Health Insurance Plan Study^SM

Power Circle Ratings Legend
- ●●●●● *Among the best*
- ●●●●○ *Better than most*
- ●●●○○ *About average*
- ●●○○○ *The rest*

Charts and graphs extracted from this press release must be accompanied by a statement identifying J.D. Power and Associates as the publisher and the J.D. Power and Associates 2011 U.S. Member Health Insurance Plan Study^SM as the source. Rankings are based on numerical scores, and not necessarily on statistical significance. JDPower.com Power Circle Ratings™ are derived from consumer ratings in J.D. Power studies. For more information on Power Circle Ratings, visit jdpower.com/faqs. No advertising or other promotional use can be made of the information in this release or J.D. Power and Associates survey results without the express prior written consent of J.D. Power and Associates.

Press Release

J.D. Power and Associates Reports:
As Health Plans in Various States Prepare for Increasing Health Insurance Enrollments, Many Health Plan Members Consider Using Health Insurance Exchanges

WESTLAKE VILLAGE, Calif.: 11 March 2013 — The introduction of health insurance exchanges is generating interest among health plan members who purchase insurance directly, as well as those who have high deductibles and/or lower levels of overall satisfaction, according to the J.D. Power and Associates 2013 Member Health Plan Study^{SM} released today.

Now in its seventh year, the study measures satisfaction among members of 136 health plans in 17 regions throughout the United States by examining seven key factors: coverage and benefits; provider choice; information and communication; claims processing; statements; customer service; and approval process. In 2013, overall member satisfaction averages 701 (on a 1,000-point scale), compared with 702 in 2012.

Nearly three-fourths (73%) of members who purchase insurance on their own instead of through their employer say they "definitely will" or "probably will" shop for coverage using a state exchange, if available. The new insurance purchasing method intends to make it easier for members to access insurance and, ideally, at more competitive rates. The desire to reduce costs may also attract all types of members to the concept of exchange purchasing. A higher percentage of members in high-deductible health plans indicate they are interested in using exchanges, compared with those in low-deductible plans (59% vs. 45%, respectively). Service quality may also play a role in shaping demand, as members with the highest levels of interest in using exchanges are those who have contacted their health plan regarding a problem during the past year (60%), compared with those who have not had a problem with their health plan (45%).

Key Findings

- **A majority (59%) of health plan members say that they had only one health plan available to select at the time of enrollment.**
- **Slightly more than one-half (51%) of all members say that their premium cost has increased during the past year.**
- **Interest in exchanges is highest among health plan members in small companies (53%), followed by those in medium (48%) and large (43%) companies.**

"As healthcare costs continue to increase and members pay a higher percentage of the premium, health plan members are increasingly aware of exactly what they are getting for their premium," said Rick Millard, senior director of the healthcare practice at J.D. Power and Associates. "If a member has experienced problems and perceives the possibility of having more control over costs through exchanges, this new purchasing method may become more appealing."

Overall, 48 percent of health plan members (combining both group and individual markets) indicate they are interested in using a state exchange, if it were available to them. Among members with group coverage, interest in state exchanges is more prevalent when their employer has not offered a choice of health plans. Members who have a choice of health insurance brands are less interested in exchanges (36%) than do those who have no choice (50%).

"Income-eligible members with high out-of-pocket costs and less tenure with a health plan are most likely to try exchanges," said Millard. "The exchange also appeals to those working at small companies who want to take more direct control over their healthcare expenses."

Satisfaction is highest among health plan members in the Michigan, Texas and East South Central regions, and is lowest among those in the Mountain and Colorado regions.

Health plans ranking highest in their respective regions (in alphabetical order) are Anthem Health Plans of New Hampshire; AvMed Health Plans; Blue Cross and Blue Shield of Alabama; Blue Cross and Blue Shield of Illinois; Blue Cross and Blue Shield of Kansas City; Blue Cross and Blue Shield of Texas; Geisinger Health Plan; Health Alliance Plan (HAP) of Michigan; HealthPartners; Independent Health Association; Kaiser Foundation Health Plan (which ranks highest in the California, Colorado, South-Atlantic and Mid-Atlantic regions); PacificSource Health Plans; SelectHealth; and UnitedHealthcare.

J.D. Power offers the following tips to health plan members and consumers who are shopping for health insurance coverage:

- When shopping for a health insurance plan, consider the cost-to-benefit ratio. Generally speaking, the higher the cost, the higher the number of plan features and healthcare provider flexibility. Conversely, while lower-cost plans may provide lower premiums, they may also provide fewer choices of plan features or healthcare providers.
- If you purchase coverage on your own, research state-sponsored health insurance exchanges to learn how they work, and particularly how your state's exchange will be offered. Beginning later this year, you may qualify for state exchanges if your income is within a certain range or if you work for a small company, which may mean the possibility of more choices of coverage at a lower cost.
- While some states are implementing exchange ratings programs based on health plan quality (e.g., did the doctor order the right tests), be sure to review J.D. Power and Associates health plan rankings, which are based on member satisfaction, to see how your plan compares in the rankings.
- Understand your coverage. Health insurance plans are sometimes difficult to understand, with complex rules for deductibles, co-payments and other expenses. If you don't have a clear understanding of the coverage and you have a choice of plans, opt for the simpler approach. For example, you may be more satisfied with fewer choices of healthcare providers in order to have coverage with less complicated costs.

The 2013 Member Health Plan Study is based on responses from more than 33,000 members of 136 commercial health plans across 17 regions in the United States. The study was fielded in December 2012 and January 2013. For more comprehensive health plan rankings for all 17 U.S. regions, please visit www.jdpower.com.

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# # #

NOTE: Two charts follow.

J.D. Power and Associates
2013 Member Health Plan Study[SM]

Regions Included in the Member Health Plan Study

California

Colorado

East South Central (Includes Alabama, Kentucky, Louisiana, Mississippi and Tennessee)

Florida

Heartland (Includes Arkansas, Iowa, Kansas, Missouri, Nebraska and Oklahoma)

Illinois-Indiana

Michigan

Mid-Atlantic (Includes Maryland, Virginia and Washington, D.C.)

Minnesota-Wisconsin

Mountain (Includes Arizona, Nevada, New Mexico and Utah)

New England (Includes Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont)

New York-New Jersey

Northwest (Includes Idaho, Oregon and Washington)

Ohio

Pennsylvania

South-Atlantic (Includes Georgia, North Carolina and South Carolina)

Texas

Source: J.D. Power and Associates 2013 Member Health Plan Study[SM]

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J.D. Power and Associates
2013 Member Health Plan Study[SM]

Top Three Plans in Overall Member Satisfaction by Region

California*
Highest: Kaiser Foundation Health Plan
Blue Shield of California

Colorado
Highest: Kaiser Foundation Health Plan
Aetna
UnitedHealthcare

East South Central
Highest: Blue Cross Blue Shield of Alabama
Blue Cross Blue Shield of Louisiana
Blue Cross Blue Shield of Tennessee

Florida
Highest: AvMed Health Plans
Aetna
Cigna
Humana
Florida Blue

Heartland
Highest: Blue Cross Blue Shield of Kansas City
Blue Cross Blue Shield of Oklahoma
Wellmark Blue Cross Blue Shield of Iowa

Illinois-Indiana*
Highest: Blue Cross Blue Shield of Illinois
Health Alliance Medical Plans

Michigan
Highest: Health Alliance Plan of Michigan
Blue Cross Blue Shield of Michigan
Priority Health

Mid-Atlantic*
Highest: Kaiser Foundation Health Plan
CareFirst Blue Cross Blue Shield

Minnesota-Wisconsin
Highest: HealthPartners
Dean Health Plan
Blue Cross Blue Shield of Minnesota

Mountain
Highest: SelectHealth
Blue Cross Blue Shield of Arizona
Regence Blue Cross Blue Shield of Utah

New England
Highest: Anthem Health Plans of New Hampshire
Tufts Associated Health Plans
Blue Cross Blue Shield of Rhode Island

New York-New Jersey
Highest: Independent Health Association
CDPHP
Empire Blue Cross Blue Shield

Northwest
Highest: PacificSource Health Plans
Group Health Cooperative
Blue Cross of Idaho
Premera Blue Cross

Ohio
Highest: UnitedHealthare
Medical Mutual of Ohio
Humana

Pennsylvania
Highest: Geisinger Health Plan
UPMC Health Plan
Highmark Blue Shield

South-Atlantic
Highest: Kaiser Foundation Health Plan
Cigna
UnitedHealthcare

Texas*
Highest: Blue Cross Blue Shield of Texas
Aetna

** No other plan in this region performs above the region average.*

Source: J.D. Power and Associates 2013 Member Health Plan Study[SM]

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United States Government Accountability Office

GAO

Report to Congressional Requesters

November 2012

CMS INNOVATION CENTER

Early Implementation Efforts Suggest Need for Additional Actions to Help Ensure Coordination with Other CMS Offices

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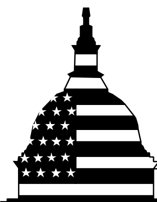

GAO-13-12

November 2012

GAO
Accountability * Integrity * Reliability

Highlights

Highlights of GAO-13-12, a report to congressional requesters

CMS INNOVATION CENTER

Early Implementation Efforts Suggest Need for Additional Actions to Help Ensure Coordination with Other CMS Offices

Why GAO Did This Study

PPACA created the Innovation Center within CMS. The purpose of the Innovation Center is to test new approaches to health care delivery and payment—known as models—for use in Medicare or Medicaid.

GAO was asked to review the implementation of the Innovation Center. Specifically, GAO: (1) describes the center's activities, funding, organization, and staffing as of March 31, 2012; (2) describes the center's plans for evaluating its models and its own performance; and (3) examines whether efforts of the center overlap with those of other CMS offices and how the center coordinates with other offices. GAO analyzed budget and staffing data; reviewed available documentation, such as Innovation Center policies and procedures and functional statements for CMS offices; and interviewed officials from the Innovation Center and other CMS offices, such as the Center for Medicare. GAO assessed how the Innovation Center coordinates in the context of federal internal control standards and key practices for collaboration from prior GAO work.

What GAO Recommends

GAO is recommending that the Administrator of CMS direct the Innovation Center to expeditiously complete its process to review and eliminate any areas of unnecessary duplication in contracts that have been awarded in one of its models. HHS agreed with this recommendation and described steps it is taking to address unnecessary duplication.

View GAO-13-12. For more information, contact Linda Kohn at (202) 512-7114 or kohnl@gao.gov.

What GAO Found

From the time it became operational in November 2010, through March 31, 2012, the Center for Medicare and Medicaid Innovation (Innovation Center) has focused on implementing 17 new models to test different approaches for delivering or paying for health care in Medicare and Medicaid. The center is still relatively early in the process of implementing these models. Eleven of the models were selected by the Innovation Center under the provision in the Patient Protection and Affordable Care Act (PPACA) that established the center, while the remaining 6 were specifically required by other PPACA provisions. The Innovation Center projects that a total of $3.7 billion will be required to fund testing and evaluation of the 17 models, with the expected funding for individual models ranging from $30 million to $931 million. As of March 2012, the center's 184 staff were organized into four groups responsible for coordinating the implementation of different models and another five groups responsible for key functions that support model implementation. Officials said that, among other things, the center's initial hiring of staff reflected the need for leadership and for specific types of expertise, such as individuals with a background in evaluation.

The Innovation Center's plans for evaluating individual models include identifying measures related to the cost and quality of care. Officials from the Centers for Medicare & Medicaid Services (CMS) told GAO that the Innovation Center had developed preliminary evaluation plans for the 17 models being implemented that, among other things, identified proposed measures. According to CMS officials, these measures will be finalized by contractors responsible for evaluating, on behalf of CMS, each model's impact on cost and quality. As of August 1, 2012, the Innovation Center had contracted for the evaluation of 10 of the 17 models. The center's plans for evaluating its own performance include aggregating data across models by using a set of core measures it has developed. In addition, the Innovation Center has taken steps to monitor its progress in implementing the 17 models through biweekly reviews of standard milestones and related data, such as the number of applications to participate in a model the center has received.

GAO identified three key examples of overlap between the 17 Innovation Center models and the efforts of other CMS offices, meaning that the efforts share similar goals, engage in similar activities or strategies to achieve these goals, or target similar populations. However, these overlapping efforts also have differences, and CMS officials said the efforts are intended to be complementary to each other. GAO also identified a number of mechanisms the Innovation Center uses to coordinate its work in order to avoid unnecessary duplication between its models and other efforts, such as multi-office meetings at the staff, director, and agency level. Further, through using these mechanisms, the Innovation Center has engaged in key practices for collaboration, including leveraging resources across offices. At the same time, the center is still working on ways to make its coordination more systematic. For example, largely because of questions raised during GAO's review, the Innovation Center initiated a process to ensure that CMS does not pay for the same service under the contracts in one of its models and those in another CMS office. However, officials told GAO that the center is still working on implementing this process and may need to take additional steps to eliminate any unnecessary duplication.

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Abbreviations

ACO	Accountable Care Organization
CCSQ	Center for Clinical Standards and Quality
CMCS	Center for Medicaid and CHIP Services
CMS	Centers for Medicare & Medicaid Services
GS	General Schedule
HEN	Hospital Engagement Network
HHS	Department of Health and Human Services
ICIP	Innovation Center Investment Proposal
Innovation Center	Center for Medicare and Medicaid Innovation
OMB	Office of Management and Budget
ORDI	Office for Research, Development and Information
PPACA	Patient Protection and Affordable Care Act
QIO	Quality Improvement Organization

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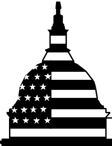

United States Government Accountability Office
Washington, DC 20548

November 15, 2012

The Honorable Orrin G. Hatch
Ranking Member
Committee on Finance
United States Senate

The Honorable Michael B. Enzi
Ranking Member
Committee on Health, Education, Labor, and Pensions
United States Senate

The Honorable Tom Coburn
Ranking Member
Permanent Subcommittee on Investigations
Committee on Homeland Security and Governmental Affairs
United States Senate

Spending on health care in the United States reached $2.6 trillion in 2010 and is expected to increase, with federal spending—driven primarily by expenditures for Medicare and Medicaid—accounting for a growing percentage of the total.[1] Complicating these trends, recent evidence suggests that higher levels of health care spending do not always lead to enhanced quality of care.[2] As a result, policymakers have sought to both

---

[1]Medicare is the federal health insurance program for persons aged 65 or over, individuals under the age of 65 with certain disabilities, and individuals with end-stage renal disease. Medicaid is a joint federal-state program that finances health care for certain categories of low-income individuals. The State Children's Health Insurance Program is a federal-state program that provides health care coverage to children 18 years of age and younger living in low-income families whose incomes exceed the eligibility requirement for Medicaid. For this report we use the term "Medicaid" to include both Medicaid and the State Children's Health Insurance Program.

[2]See for example, E. S. Fisher and H. G. Welch, "Avoiding the Unintended Consequences of Growth in Medical Care: How Might More Be Worse?" *Journal of the American Medical Association*, vol. 281, no. 5 (1999): 446-453; E. S. Fisher et al., "The Implications of Regional Variations in Medicare Spending; Part 1: The Content, Quality, and Accessibility of Care," *Annals of Internal Medicine*, vol. 138, no. 4 (2003): 273-287; E. S. Fisher et al.,"The Implications of Regional Variations in Medicare Spending; Part 2: Health Outcomes and Satisfaction with Care," *Annals of Internal Medicine*, vol. 138, no. 4 (2003): 288-298; and Joseph P. Newhouse and the Insurance Experiment Group, *Free for All? Lessons from the RAND Health Insurance Experiment* (Cambridge, Mass.: Harvard University Press, 1993).

reduce costs and improve quality by researching ways of changing how health care services are delivered and health care providers are paid. To identify approaches that work, policymakers need credible information on the effects of the approaches on cost and quality. In 2010, the Patient Protection and Affordable Care Act (PPACA) created the Center for Medicare and Medicaid Innovation (Innovation Center) within the Centers for Medicare & Medicaid Services (CMS)—the agency within the Department of Health and Human Services (HHS) that administers Medicare and Medicaid.[3] The purpose of the Innovation Center is to test new approaches to health care delivery and payment—known as models—in order to reduce Medicare and Medicaid expenditures while preserving or enhancing quality of care for beneficiaries of the programs.[4] Although CMS conducted similar testing through demonstrations prior to PPACA, the recent law provides the Innovation Center with additional authority.[5] For example, unlike for demonstrations CMS has frequently conducted in the past, models tested under the provision establishing the Innovation Center can, under certain conditions, be expanded—including on a nationwide basis—through rulemaking instead of requiring legislation.[6] In addition, PPACA significantly increased the funding available to CMS to test new approaches. According to an analysis by the Medicare Payment Advisory Commission, CMS's funding for research, demonstrations, and evaluations has historically been appropriated annually, and was less than $1 billion for the period of fiscal years 2000

[3]Pub. L. No. 111-148, §§ 3021, 10306, 124 Stat. 119, 389, 939 (codified at 42 U.S.C. § 1315a).

[4]Tests of models are initially limited in duration and put into effect through agreements with participants, such as providers, that may be located in several geographic areas or be specific to particular areas. Participants apply and are selected by the Innovation Center generally through a competitive process and may enter into a variety of agreements, such as grants and cooperative agreements.

[5]Historically, CMS's efforts to test new approaches to health care delivery and payment have been referred to as "demonstrations." In this report, we will use the term "models" when discussing approaches initiated by the Innovation Center, and "demonstrations" when discussing approaches that were initiated prior to the establishment of the Center.

[6]Another important difference is that while approval of prior demonstrations has generally been contingent on a determination of budget neutrality—that is, that estimated federal expenditures under the model are expected to be no more than they would have been without the model— PPACA provides that HHS cannot make such a requirement for models tested under the provision establishing the Innovation Center.

through 2010.[7] In contrast, PPACA provided the Innovation Center with a dedicated source of funding, appropriating $10 billion for its activities for the period of fiscal years 2011 through 2019 and $10 billion per decade beginning in fiscal year 2020.[8]

PPACA required CMS to make the Innovation Center operational by January 1, 2011, and the center became operational in November 2010. Since that time, some members of Congress have raised questions about the extent to which models the Innovation Center has selected for testing will lead to reduced costs and improved quality in health care, particularly given the amount appropriated for its work. They have also raised questions about the potential for overlap between efforts of the Innovation Center and those of existing centers and offices within CMS,[9] which, if not effectively coordinated, could result in the inefficient use of federal resources through unnecessary duplication.[10] We were asked to review the implementation of the Innovation Center. In this report, we: (1) describe the Innovation Center's activities, funding, organization, and staffing; (2) describe the Innovation Center's plans for evaluating its models and its own performance; and (3) examine whether efforts of the Innovation Center overlap with those of other CMS offices and assess how the center coordinates with other offices.

To describe the Innovation Center's activities, funding, organization, and staffing, we focused our review on information as of March 31, 2012—about 2 years after the enactment of PPACA. We reviewed documents,

[7]See Medicare Payment Advisory Commission, *Report to Congress: Aligning Incentives in Medicare* (Washington, D.C.: 2010).

[8]PPACA also appropriated $5 million for fiscal year 2010 activities. Amounts appropriated by PPACA are to remain available until expended.

[9]For the purposes of this report, we refer to both centers and offices within CMS as offices.

[10]We have previously defined "overlap" as occurring when two or more agencies or programs have similar goals, engage in similar activities or strategies to achieve them, or target similar beneficiaries, and observed that while some degree of overlap may be warranted due to the nature or magnitude of the federal effort, overlap can also result in unnecessary duplication of efforts. We have previously defined "duplication" as occurring when two or more agencies or programs are engaged in the same activities or provide the same services to the same beneficiaries. See GAO, *2012 Annual Report: Opportunities to Reduce Duplication, Overlap and Fragmentation, Achieve Savings, and Enhance Revenue*, GAO-12-342SP (Washington, D.C.: Feb. 28, 2012).

including information on models the center was implementing as of this date, and planning documents, such as organizational charts.[11] We also reviewed budget and staffing data for the Innovation Center. We interviewed knowledgeable agency officials about their efforts to ensure the quality of the data, checked for anomalies, and determined these data were sufficiently reliable for our purposes. In order to obtain more in-depth information on center activities, we reviewed examples of the types of documents used in implementing models, such as a model's Innovation Center Investment Proposal (ICIP), which is the document developed to obtain approval for models or initiatives. Finally, we interviewed Innovation Center officials and officials in CMS's Office of Financial Management.

To describe the Innovation Center's plans for evaluating its models and its own performance, we reviewed documents, such as descriptions of the center's model evaluation process and internal tracking documents. We also reviewed examples of more-detailed information, such as documents discussing evaluation plans for individual models the center was implementing as of March 31, 2012, and reviewed information on the center's progress in evaluating models. In addition, we reviewed the statement of work for a contractor to evaluate the Innovation Center's operations. To supplement this information, we interviewed Innovation Center officials and officials from CMS's Office of the Actuary.

To examine whether efforts of the Innovation Center overlap with those of other CMS offices and assess how the center coordinates with other offices, we reviewed the key functions of all offices within CMS, using information that was available on CMS's website to identify areas of potential overlap. We then interviewed Innovation Center officials, as well as officials from other CMS centers and offices, including the Center for Medicare, the Center for Clinical Standards and Quality (CCSQ), and the Center for Medicaid and CHIP Services (CMCS), to obtain more-specific information about the efforts they conduct. On the basis of these interviews and review of related documentation, such as statements of

[11]Model implementation involves a period of planning and development followed by a period of testing and evaluation. Planning and development include a series of steps, such as developing an evaluation approach and obtaining approval from CMS, HHS, and the Office of Management and Budget (OMB). Testing and evaluation also includes a series of steps, such as the collection of cost and quality data and sharing feedback with model participants.

work for program contractors, we assessed whether Innovation Center models being implemented as of March 31, 2012, had similar goals, engaged in similar activities or strategies to achieve these goals, or targeted similar beneficiaries as the efforts of other CMS offices. While efforts identified in this report may not represent the full universe of overlapping efforts between the Innovation Center and other CMS offices, we conducted a systematic examination to identify key examples of where overlap may have occurred. Finally, we interviewed the same officials to obtain information on how the Innovation Center coordinates its efforts with other CMS offices, and reviewed corroborating documentation, such as center policies and procedures, when available. We assessed how the center coordinates within the context of federal internal control standards and key practices for collaboration identified in prior GAO work.[12] According to federal internal control standards, an entity should, among other things, have the policies and procedures necessary to provide reasonable assurance of the effectiveness and efficiency of its operations, including the use of resources, and ensure that these policies and procedures are appropriately documented.[13]

We conducted our performance audit from February 2012 through November 2012 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[12]These collaboration practices are: (1) defining and articulating a common outcome; (2) establishing mutually reinforcing or joint strategies; (3) identifying and addressing needs by leveraging resources; (4) agreeing on roles and responsibilities; (5) establishing compatible policies, procedures, and other means to operate across agency boundaries; (6) developing mechanisms to monitor, evaluate, and report on results; (7) reinforcing agency accountability for collaborative efforts through agency plans and reports; and (8) reinforcing individual accountability for collaborative efforts through performance-management systems. See GAO, *Results-Oriented Government: Practices That Can Help Enhance and Sustain Collaboration among Federal Agencies*, GAO-06-15 (Washington, D.C.: Oct. 21, 2005).

[13]See GAO, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999).

Background

While PPACA gives CMS discretion in how to implement the Innovation Center, such as the composition of its staff, the law also established certain requirements for the center. For example, PPACA requires that, in carrying out its duties described in the law, the Innovation Center consult with representatives of relevant federal agencies and clinical and analytical experts with expertise in medicine or health care management. It also requires that, of amounts appropriated to the center, the center make no less than $25 million available for model implementation each fiscal year starting in 2011. In addition, PPACA requires that the Innovation Center evaluate each model to measure its effects on spending and quality of care, and that these evaluations be made public. Further, PPACA requires the Innovation Center to modify or terminate a model any time after testing and evaluation has begun unless it determines that the model either improves quality of care without increasing spending levels, reduces spending without reducing quality, or both.

In addition to these requirements, when selecting models, PPACA requires the Innovation Center to determine that a model addresses a situation in which deficits in care were leading to poor clinical outcomes or unnecessary spending. The law also describes types of models that the Innovation Center could consider in selecting models to test; however the center is not limited to this list. Examples of model types include changing the way primary care providers are reimbursed for services and improving care for patients recently discharged from the hospital. PPACA also directs that in selecting models, the Innovation Center give preference to those that improve the coordination, quality, and efficiency of health care services and lists additional factors for consideration, such as whether the model uses certain technology to help achieve its goals.

Finally, PPACA also makes certain requirements not applicable to models tested under the provision establishing the Innovation Center that were applicable to demonstrations CMS has frequently conducted in the past. For example, while prior demonstrations generally required legislation in order to be expanded, PPACA allows CMS to expand Innovation Center models more broadly into Medicare or Medicaid—including on a nationwide basis—through the rulemaking process if the following conditions are met: (1) the agency determines that the expansion is expected to reduce spending without reducing the quality of care or improve quality without increasing spending, (2) CMS's Office of the

Actuary certifies that the expansion will reduce or not increase net spending, and (3) the agency determines that the expansion would not deny or limit coverage or benefits for beneficiaries.[14] In addition, PPACA makes inapplicable certain requirements that have previously been cited as administrative barriers to the timely completion of demonstrations.[15] Specifically, PPACA provides the following:

- HHS cannot require that an Innovation Center model be budget neutral, that is, designed so that estimated federal expenditures under the model are expected to be no more than they would have been without the model, prior to approving a model for testing.
- Certain CMS actions in testing and expanding Innovation Center models cannot be subject to administrative or judicial review. For example, the selection of models for testing or expansion is not subject to review by the agency or the courts.
- The Paperwork Reduction Act does not apply to Innovation Center models. Under the Paperwork Reduction Act, agencies generally are required to submit all proposed information collections to the Office of Management and Budget (OMB) for approval and provide a 60-day period for public comment on collections, among other things, when they want to collect data on 10 or more individuals.[16]

[14]In addition, PPACA provides that demonstrations conducted under 42 U.S.C. § 1395cc-3 may also be expanded under the same conditions. 42 U.S.C. § 1315a(c). These demonstrations comprise Medicare's Health Care Quality Demonstration Program.

[15]See for example Medicare Payment Advisory Commission, *Report to Congress: Aligning Incentives in Medicare*, (Washington, D.C.: 2010).

[16]44 U.S.C. §§ 3501-3520.OMB assists the President in overseeing the preparation of the federal budget and in supervising its administration in executive branch agencies. OMB also oversees and coordinates the administration's procurement, financial management, information, and regulatory policies.

The Innovation Center's Activities, Funding, Organization, and Staffing Focused on Implementing 17 New Models

From the time it became operational in November 2010, through March 31, 2012, the Innovation Center's activities and use of funding focused on implementing 17 new models to test different approaches to health care delivery and payment in Medicare and Medicaid. During this period, the Innovation Center hired and organized staff into groups to implement models and to provide for the key functions that support model implementation.

Innovation Center Activities and Funding Have Focused on Implementing 17 New Models

From the time it became operational in November 2010, through March 31, 2012, the Innovation Center announced the implementation of 17 new models[17] designed to test different approaches to health care delivery and payment in Medicare and Medicaid.[18] These models generally fall into three different types on the basis of the delivery and payment approaches tested. The center's "Patient care" models test approaches that are designed around improving care for clinical groups of patients such as patients needing heart bypass surgery. "Seamless care" models test approaches designed to improve coordination of care for a patient population across care settings, such as the coordination of inpatient and outpatient care for all of a provider's Medicare beneficiaries. "Preventive care" models test approaches designed to improve health, such as incentive programs to prevent smoking. The 17 models vary by the program and beneficiaries targeted. For example, some target Medicare or Medicaid beneficiaries specifically, whereas others are open to beneficiaries of either program. In addition, three models have been designed to target individuals who are covered by both Medicare and Medicaid. The models also vary in terms of the types of participants

[17]While there are 17 models, each model may include multiple strategies for achieving changes in health care delivery or payment. For example, Innovation Center models may engage broad segments of the health care delivery system simultaneously, including multiple delivery settings, purchasers, or consumers. In another example, 1 of the 17 models—Strong Start for Mothers and Newborns—tests, among other things, three different ways of providing enhanced prenatal care.

[18]In addition, the Innovation Center launched two other initiatives intended to support innovation. These initiatives are not models because they did not involve a test of a particular payment or delivery approach. For example, the Innovation Advisors Program provides training and support to individuals across the country so that they can help their organizations implement new approaches to care delivery.

involved, ranging, for example, from physician group practices to Federally Qualified Health Centers, to health plans, to state Medicaid programs.[19]

Of these 17 models, 11 were selected by the Innovation Center under the PPACA provision that established the center and, as a result, certain requirements that have applied to demonstrations CMS has frequently conducted in the past are not applicable to these models. The Innovation Center selected the 11 models for implementation by reviewing model types identified in PPACA and ideas submitted by CMS staff as well as through a variety of mechanisms designed to obtain ideas from beneficiaries, providers, payers, state policymakers and others.[20] Selection criteria—which are available to the public on the Innovation Center's website—include focusing on health conditions that offer the greatest opportunity to improve care and reduce costs, and meeting the needs of the high-admission-rate hospitals most vulnerable populations.

The remaining six new models the Innovation Center is implementing were specifically required by other PPACA provisions. For example, the center is implementing a model required by PPACA that tests whether partnerships between and community-based organizations can improve transition care services for Medicare beneficiaries.[21] The degree of flexibility that the Innovation Center has in implementing these six models varies by each model's specific statutory authority.[22]

[19]Federally Qualified Health Centers are health centers that have received a "Federally Qualified Health Center" designation from CMS and provide comprehensive community-based primary and preventive care services in medically underserved areas or to medically underserved populations. Federally Qualified Health Centers must meet certain federal requirements and enjoy certain federal benefits, such as enhanced Medicaid reimbursement rates.

[20]These mechanisms included the Innovation Center's online web program and "listening session" meetings held across the country in 2010.

[21]Pub. L. No. 111-148, § 3026, 124 Stat. at 413 (codified at 42 U.S.C. § 1395b-1 note).

[22]For example, for the Independence at Home model, PPACA provides that the Innovation Center may waive such provisions of titles XVIII and XI of the Social Security Act as is determined necessary to implement the program. 42 U.S.C. § 1395cc-5. In contrast, the Treatment of Certain Complex Diagnostic Tests model does not include this broad waiver authority. 42 U.S.C. § 1395l note. See app. I for more information on these models.

The Innovation Center projects that the total funding required to test and evaluate these 17 models will be $3.7 billion over their lifetime, including $2.7 billion for the 11 models selected by the Innovation Center and $1.0 billion for the 6 models specifically required by other provisions of PPACA.[23] The expected funding for individual models ranges from $30 million to $931 million, depending on model scope and design. Officials said that the period required to test and evaluate an individual model typically ranges from 3 to 5 years. With regard to the Innovation Center's annual expenditures, as of March 31, 2012, the Innovation Center forecast that most of its fiscal year 2012 budget—or 76.8 percent—would be spent implementing the 11 models that were selected for implementation by the Innovation Center.[24] Table 1 provides funding information on the 17 Innovation Center models, including total funding for models over their lifetime, by model type. Appendix I provides additional information about individual models.

[23]These estimates include programmatic costs, such as payment to providers, and acquisition costs, such as contracts to support testing and evaluation of models. They do not include administrative costs, such as CMS staff salaries.

[24]The Innovation Center's total fiscal year 2012 budget was expected to be $1.2 billion. Outside of the money spent implementing the 11 models, 13.8 percent of the budget was expected to be spent on implementing the other 6 PPACA models and on other demonstrations that predated the Innovation Center. An estimated 5.7 percent was expected to be spent on programmatic resources that support all models and 3.7 percent was expected to be spent on administrative costs that are not included in implementation costs. The Innovation Center's annual funding comes primarily from the appropriation in the PPACA provision establishing the center. However, the center also receives funding from amounts specified in other sections of PPACA for the testing of specific models provided for in those sections. Finally, the center receives funding from the annual appropriation for CMS.

Table 1: Number of Models and Total Funding over Lifetime by Model Type, as of March 31, 2012

Model type	Number of models of this type	Total funding in millions of dollars[a]
Models selected by the Innovation Center		
Patient care[b]	4	**$889**
Seamless care[c]	6	**837**
Preventive care[d]	—	**—**
Other[e]	1	**931**
Subtotal	**11**	**2,657**
Models specifically required by PPACA		
Patient care[b]	3	**380**
Seamless care[c]	2	**530**
Preventive care[d]	1	**100**
Subtotal	**6**	**1,010**
Total	**17**	**$3,667**

Source: GAO analysis of CMS data.

Notes: Section 3021 of PPACA established the Innovation Center and authorized the selection of models to test using the funds appropriated to it in that section. Pub. L. No. 111-148, §§ 3021, 10306, 124 Stat. 119, 389, 939 (codified at 42 U.S.C. § 1315a). For models selected by the Innovation Center, the center obtains approval from CMS, HHS, and OMB for the amount it expects will be required to test and evaluate the models. In addition to the models selected by the Innovation Center, there are models specifically required by other PPACA provisions that the Innovation Center is responsible for implementing. For these models, the funding amount is the amount appropriated in each model's PPACA provision.

[a]Includes programmatic costs, such as payment to providers, and acquisition costs, such as contracts to support testing and evaluation of models. Does not include administrative costs, such as CMS staff salaries.

[b]Patient care models test approaches to health care delivery and payment that are designed around improving care for clinical groups of patients such as patients needing heart bypass surgery.

[c]Seamless care models test approaches designed to improve coordination of care for a patient population across care settings.

[d]Preventive care models test approaches designed to improve health, such as incentive programs to prevent smoking.

[e]One model includes grants for multiple types of models.

Innovation Center Model-Implementation Process

Planning and Development

- Solicit ideas and select models to develop (except for models specifically required in PPACA).
- Develop an Innovation Center Investment Proposal that includes the proposed model design and evaluation approach.
- Obtain approval from CMS, HHS, and OMB, and announce model.
- Solicit, select, and establish agreements, such as grants or cooperative agreements, with participants, such as providers or health plans.
- Solicit and select contractors for testing and evaluating model (evaluation contractors are not always hired before testing begins).

Testing and Evaluation

- Conduct test of model in which participants and CMS put specified changes to health care delivery and payment into effect.
- Conduct evaluation of model, which includes evaluation while the test is ongoing, as well as completing a final evaluation of model outcomes.
- Determine whether to terminate, modify, or recommend expanding model, which can occur at any time during the testing and evaluation period depending on evaluation results (models specifically required in PPACA may require different steps in considering expansion).

As of August 1, 2012, the Innovation Center was still relatively early in the process of implementing the 17 models. CMS officials explained that this process includes a series of steps to develop and prepare the model for testing followed by a testing and evaluation period that is typically 3 to 5 years in which, among other things, participants and CMS put specified changes to health care delivery or payment into effect. (See sidebar.) While the Innovation Center had started testing 12 of the 17 models as of August 1, 2012, nearly all of these tests had started within the prior 12 months, and 5 had started within the prior 6 months.[25] Thus, the models still have a significant portion of their testing and evaluation period remaining. In addition, for the 5 models that had not yet started testing, the Innovation Center was still completing the steps necessary to start testing.[26] Appendix II provides additional information about the general process used to implement models.

In addition to the 17 models, the Innovation Center also assumed responsibility for 20 demonstrations that were initiated prior to the Innovation Center's formation. Responsibility for the demonstrations was moved to the Innovation Center in March 2011, when the demonstration and research and evaluation groups of CMS's former Office for Research, Development and Information (ORDI) were brought into the Innovation Center through reorganization.[27] As of August 1, 2012, testing of 9 of these 20 demonstrations had ended, although evaluation activities were still ongoing for 4 of them. The demonstrations were initiated under the Medicare Health Care Quality Demonstration Program which enables CMS to select which demonstrations to conduct,[28] or because they were

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[25]Of the 12 models, 7 were selected by the Innovation Center under the PPACA provision that established the center, and the remaining 5 were specifically required by other PPACA provisions.

[26]Of the 5 models, 4 were selected by the Innovation Center under the PPACA provision that established the center, and the remaining 1 was specifically required by another PPACA provision.

[27]The remaining group within ORDI—the data group—was originally merged with CMS's Center for Strategic Planning and later with its Office for Enterprise Management.

Whereas most Medicare demonstrations were consolidated under the Innovation Center when it merged with parts of ORDI, state Medicaid demonstrations are overseen by CMCS. CMS officials said that where Medicare demonstrations are still being conducted outside of the Innovation Center, it is generally because the effort was already ongoing within an office other than ORDI when the Innovation Center was established.

[28]42 U.S.C. § 1395cc-3.

specifically required by various pre-PPACA statutes. Like the Innovation Center's models, the demonstrations test a range of delivery and payment approaches; for example, one demonstration tests the use of care management—a particular approach to coordinating and managing health services—for high-cost Medicare beneficiaries while another tests approaches for preventing and treating cancer among minorities in Medicare.

The Innovation Center's Organization and Staffing Reflect Its Focus on the 17 Models and Other Key Functions That Support Model Implementation

As of March 31, 2012, the Innovation Center's 184 staff were organized into nine groups and the Office of the Director. Four of the nine groups are generally responsible for coordinating the implementation of models. Three of these four groups—the Patient Care Models, Seamless Care Models, and Preventive Care Models Groups—focus on models selected by the Innovation Center under the PPACA provision that established the center.[29] The Medicare Demonstrations group is generally responsible for implementing models specifically required by other PPACA provisions as well as the CMS demonstrations that existed prior to the establishment of the Innovation Center. Staff in these four groups coordinate planning, develop model designs, and obtain approval for their models from CMS and HHS. Once a model is approved, staff in these groups coordinate the remaining implementation steps, including soliciting and selecting participants and overseeing the model during the testing and evaluation period.

The remaining five groups have primary responsibility for key functions that support model implementation. The Policy and Programs Group reviews ideas submitted for consideration as possible models and seeks to ensure a balanced portfolio of different types of models. The Rapid Cycle Evaluation Group is responsible for evaluation of models, including collecting data on and providing feedback to model participants about their performance. The Learning and Diffusion Group facilitates learning within models and disseminates the lessons learned across models so that participants can benefit from the experiences of other models. The

[29]However, as of March 31, 2012, 3 of the 11 models selected by the Innovation Center were targeted at beneficiaries of both Medicare and Medicaid and were coordinated by CMS's Federal Coordinated Health Care Office. Two models were coordinated by two of the other groups within the Innovation Center, the Learning and Diffusion Group and the Policy and Programs Group. One of the models selected by the Innovation Center was coordinated by the Medicare Demonstrations Group.

Stakeholder Engagement Group conducts outreach to potential stakeholders to gain support and solicit ideas for innovative models, as well as outreach to potential participants—such as physician groups and hospitals—to inform them of the opportunity to participate in models. The Business Services Group coordinates with other CMS centers and offices to provide administrative and business support to the Innovation Center in areas such as budgeting, contracting, and project management.

CMS officials explained that the 184 staff hired between the time the Innovation Center became operational in November 2010, and March 31, 2012, were distributed across the Office of the Director and the nine groups in part because of an initial need for expertise with certain model types and certain key functions. For example, because most of the models that the Innovation Center selected for implementation were Patient Care and Seamless Care Models, more staff were hired in those groups than in the Preventive Care Models Group.[30] Similarly, the Rapid Cycle Evaluation Group and the Business Services Group were among the largest groups by staff size because of (1) the Innovation Center's need for evaluation expertise when selecting which models to test as well as its responsibility for evaluating existing demonstrations and (2) the need for staff to carry out key administrative activities right away, including contract solicitation, budget development, and hiring. Because the Innovation Center assumed responsibility for prior CMS demonstrations, staff from ORDI, which was responsible for implementing the demonstrations, were reassigned to the Innovation Center to form the Medicare Demonstrations Group and part of the Rapid Cycle Evaluation Group. Table 2 provides information on the staff size for each group in the Innovation Center as of March 31, 2012.

[30]As of March 31, the Innovation Center had not yet announced a model coordinated by the Preventive Care Models Group; however CMS officials told us that this group is overseeing a number of approaches funded through the Health Care Innovation Awards model.

Table 2: Innovation Center Staff by Group, as of March 31, 2012

Office or group	Purpose	Total staff
Office of the Director	Manage the Innovation Center	**8**
Groups organized by type of model		
Seamless Care models	Develop Seamless Care models and coordinate implementation. Seamless care models test approaches designed to improve coordination of care for a general patient population across care settings.	**18**
Patient Care models	Develop Patient Care models and coordinate implementation. Patient care models test approaches designed around improving care for clinical groups of patients, such as patients needing heart bypass surgery.	**11**
Preventive Care models	Develop Preventive Care models and coordinate implementation. Preventive care models test approaches designed to improve health, such as incentive programs to prevent smoking.	**2**
Medicare Demonstrations	Coordinate implementation for models specifically required by other PPACA provisions and for demonstrations that existed before PPACA and the Innovation Center.	**29**
Groups organized by key function		
Rapid Cycle Evaluation	Coordinate evaluation of models including providing ongoing feedback to participants and final model evaluations.	**38**
Business Services	Coordinate with other CMS centers to provide administrative support for budgeting, contracting and project management.	**33**
Policy and Programs	Manage the intake of ideas, and help ensure balanced portfolio of models.	**9**
Learning and Diffusion	Communicate with model participants about what is working across models.	**27**
Stakeholder Engagement	Communicate with potential stakeholders and the public.	**9**
Total		**184**

Source: GAO analysis of CMS information.

CMS officials explained that initial hiring of staff also reflected other needs such as the need for rapid recruitment, the need to balance the number of staff with expertise in CMS policies and procedures with staff who had experience in the private sector, and the need for leadership to guide the development of the new center's activities.

Rapid recruitment: Approximately 40 percent of the staff working in the Innovation Center as of March 31, 2012, was brought on board within the first 5 months from when it became operational in November 2010.[31] In

[31] Of the staff brought on board within the first 5 months from when the Innovation Center became operational in November 2010, about 82 percent were reassignments from within CMS, and officials told us most of these were from ORDI.

order to help the center get started quickly, CMS gave the Innovation Center authority to hire staff directly until March 31, 2011, after which it followed standard hiring procedures. Of the 184 staff in CMMI as of March 31, 2012, 64 had been hired through the Innovation Center's direct-hire authority.

Balancing the need for CMS expertise with expertise in the private sector: CMS officials said the Innovation Center sought a balance of staff who had expertise with CMS policies and procedures and staff from outside of the agency in the private sector. Of the staff on board as of March 31, 2012, about 54 percent were reassignments from within CMS, while about 46 percent were new hires from outside of the agency, and officials explained that most of these were from the private sector.

Leadership: During its first year, CMS officials said the center sought to build its leadership. When compared with data for CMS as a whole for 2011, the distribution of the center's staff as of March 31, 2012, shows a higher percentage of Innovation Center staff at the General Schedule (GS)-15 employment level,[32] which is one of the higher management levels.[33] Specifically, 23.4 percent of the Innovation Center's staff were in the GS-15 level, compared with 11.5 percent for CMS as a whole. At the same time, the proportion of staff at other upper levels, including the Senior Executive Service level, in the Innovation Center was similar to that of CMS as a whole. Table 3 provides information about Innovation Center staff by employment level as of March 31, 2012.

[32]The General Schedule is a classification and pay system for civilian Federal employees. The General Schedule has 15 grades—GS-1 (lowest) to GS-15 (highest). Senior Executive Service positions are Federal employee positions that are classified above GS-15.

[33]CMS Officials told us that the higher level of staff at the GS-15 level reflects a higher concentration of researchers at the Ph.D. and master's degree level supporting Innovation Center functions.

Table 3: Innovation Center Staff and CMS Staff by Employment Level

Federal General Schedule (GS) employment level[a]	Innovation Center (as of 3/31/12)		CMS (as of 9/30/11)	
	Number	Percentage	Number	Percentage
GS Grades 1–8	4	2.2%	134	3.1%
GS-9	16	8.7	194	4.5
GS-10	0	0.0	1	< 0.1
GS-11	19	10.3	221	5.1
GS-12	12	6.5	723	16.7
GS-13	60	32.6	1899	43.8
GS-14	22	12.0	586	13.5
GS-15	43	23.4	499	11.5
Senior Executive Service	2	1.1	74	1.7
Other	6	3.3	0	0.0
Total	**184**	**100%**	**4331**	**100%**

Source: GAO analysis of CMS data.

Notes: Percentages do not add to 100 due to rounding.

[a]The General Schedule is a classification and pay system for civilian federal employees. The General Schedule has 15 grades—GS-1 (lowest) to GS-15 (highest). Senior Executive Service positions are federal employee positions that are classified above GS-15.

CMS officials said that the Innovation Center plans to hire additional staff with an emphasis on hiring into the three groups—the Seamless Care, Patient Care, and Preventive Care Models groups—that focus on models selected by the Innovation Center. Officials told us that the center's goal is to have a total of 338 staff and noted that, compared to initial hiring, which focused on staff at leadership levels, future hiring will emphasize lower GS levels.[34]

[34]Officials said that the Innovation Center had received approval from OMB for funding to hire 125 staff in addition to the 154 staff it had on board as of January 1, 2012.

The Innovation Center's Evaluation Plans Include Identifying Measures, Hiring Contractors, and Aggregating Data across Models

The Innovation Center's plans for evaluating its models include identifying measures related to the cost and quality of care and hiring contractors to evaluate the models. The Innovation Center's plans for evaluating its own performance include aggregating data on cost and quality measures to determine the overall impact of the center and monitoring its progress implementing models.

The Innovation Center's Plans for Evaluating Models Include Identifying Measures Related to the Cost and Quality of Care and Hiring Contractors

As part of its evaluation of individual models, the Innovation Center plans to identify measures related to the cost and quality of care. CMS officials said that, as of August 1, 2012, the Innovation Center had developed preliminary evaluation plans for each of the 17 models being implemented. In these plans, the center has identified preliminary cost and quality measures to be used to evaluate the 17 models.[35] According to CMS officials, in identifying the preliminary measures, they generally selected cost and quality measures that were well accepted in the health care industry, including those developed or endorsed by national organizations, such as the National Quality Forum and the Agency for Healthcare Research and Quality.[36] Officials said that they also identified measures for which data sources were readily available, such as claims data and standard patient surveys conducted by providers.

The preliminary cost and quality measures the Innovation Center identified vary for different models. For example, preliminary cost measures include the average total cost of care per Medicare beneficiary per year and the cost per hospitalization and related outpatient care and subsequent hospitalizations for certain types of conditions. In the case of quality, preliminary measures identified by the Innovation Center vary by the type of care involved, such as the percentage of patients whose blood

[35]The evaluation plans also include information on the types of research questions the Innovation Center wants answered, possible analytic approaches to be taken when conducting the evaluations, and reporting guidelines.

[36]The National Quality Forum is a nonprofit organization that fosters agreement on national standards for measurement of health care performance data. The Agency for Healthcare Research and Quality is an agency within HHS that supports research and dissemination of information about health care safety and quality.

pressure exceeds a certain level (primary care); newborn birth-weight (prenatal care); and the number of adverse events, such as hospital-acquired infections (hospital care). See table 4 for examples of preliminary measures identified by the Innovation Center and intended for use for different types of care.

Table 4: Examples of Preliminary Measures for Innovation Center Models Involving Different Types of Care

Model name	Model purpose and type of care	Cost measures	Quality measures
Federally Qualified Health Center Advanced Primary Care Practice[a]	Test the effect of an advanced primary care practice model	• Average annual cost of care per beneficiary (Medicare Parts A and B costs)[b]	• Patient rating of care experience • Inappropriate medication use • Rate of provision of preventive services
Partnership for Patients	Test the effect of multiple strategies to improve patient safety in hospitals, including reducing preventable hospital-acquired conditions and reducing 30-day readmissions[c]	• Cost for initial hospitalization, for outpatient services, and for subsequent hospitalizations, for cases of preventable hospital-acquired conditions	• Rate of certain hospital-acquired conditions • Rate of 30-day readmissions
Strong Start for Mothers and Newborns	Test, among other things, the effect of three different approaches to providing enhanced prenatal care	• Total cost of care for pregnancy, for the delivery, and for care provided to infant in first year	• Gestational age at delivery • Rate of low birth weight births • Timeliness of prenatal care

Source: GAO analysis of CMS information.

[a]Federally Qualified Health Centers are health centers that have received a “Federally Qualified Health Center” designation from CMS and provide comprehensive community-based primary and preventive care services in medically underserved areas or to medically underserved populations. Federally Qualified Health Centers must meet certain federal requirements and enjoy certain federal benefits, such as enhanced Medicaid reimbursement rates.

[b]Medicare is the federal health insurance program for persons aged 65 or over, individuals under the age of 65 with certain disabilities, and individuals with end-stage renal disease. Medicare Part A covers hospital services and Medicare Part B covers physician and other outpatient services.

[c]Hospital-acquired conditions are conditions that a patient acquires while an inpatient in the hospital, such as catheter-associated urinary tract infections or injuries from falls. The 30-day hospital readmission rate is the rate at which patients discharged from the hospital return within 30 days. While some readmissions are unavoidable, such as those not related to the initial diagnosis, others can be prevented through the use of best practices of care.

Preliminary measures the Innovation Center identifies will be finalized with contractors responsible for evaluating models on behalf of CMS. According to CMS officials, the Innovation Center plans on hiring

contractors to evaluate its models.[37] The Innovation Center uses its preliminary evaluation plans as the basis for developing solicitations for and selecting contractors, who will be asked to propose specific evaluation approaches. Officials said that after contracts are awarded, the Innovation Center goes through a "design phase" with the contractor where they reach agreement on the final evaluation plan, including the measures of cost and quality of care that will be used. As of August 1, 2012, the Innovation Center had contracted with evaluators for 10 of the 17 models and had finalized measures for 2 models.[38] The center anticipated awarding contracts for 6 of the remaining models by the end of fiscal year 2012 and for the other remaining model—the Strong Start for Mothers and Newborns model—by March 2013.

In addition to finalizing the selection of a model's measures, each contractor will be responsible for collecting data for the measures, and assessing the model's impact on cost and quality. To make this assessment, CMS officials said the evaluation contractors will generally compare the model's cost and quality outcomes to the outcomes for a comparison group of beneficiaries or providers that did not participate in the model by using a variety of statistical techniques.[39] Officials also said that to ensure that any differences observed between model participants and the comparison group are due to the model's approach as opposed to other factors, they have set a threshold of statistical significance that they will use for all models. While a model's testing and evaluation period is typically set at 3 to 5 years, officials noted that in some cases it may be clear from the data within 1 or 2 years whether a model has had a positive impact on the cost and quality of care and should be recommended for implementation more broadly in Medicare or Medicaid,

[37]Hiring contractors to conduct evaluations of models is consistent with how CMS conducted evaluations of demonstrations initiated prior to the Innovation Center's formation.

[38]Officials said that before measures are finalized with contractors, evaluation activities may still be conducted using preliminary measures.

[39]Officials told us that comparison groups will be matched to model participants along a variety of measurable dimensions, such as provider and market-specific characteristics, and that particular care will be taken to identify the impact of each reform in the context of other models or interventions. Officials also told us that in certain cases, it may not be possible to develop comparison groups for models. In these cases, the center will compare cost and quality outcomes for model participants before and after the start of the model.

or that it has increased costs and should be discontinued. Alternatively, there may also be cases where the results at the end of the testing and evaluation period show that a model saves money but not at the threshold of statistical significance set by the Innovation Center.[40] CMS officials told us that impact assessments will be ongoing, but will not begin until a model has been under way for the amount of time expected for the change in health care delivery or payment to start producing results.[41] Officials said that they received data for their first impact assessment on August 31, 2012, although they emphasized that early impact assessments may not show clear results.

As a complement to assessing the impact of models on the cost and quality of care, evaluation contractors will be asked to conduct site visits and interviews to obtain qualitative information about the different strategies participants may use to deliver care under each model. For example, for models that seek to incentivize better coordination of care, participants may implement different strategies to support care coordination, such as increasing staffing or investing in technology. Contractors will analyze whether different strategies are associated with particular cost and quality outcomes.

Innovation Center officials told us that information collected by contractors will also be shared on a regular basis with model participants. The purpose of what the center refers to as "rapid cycle" feedback is to provide timely information so that participants can make improvements during the testing period of the model. For example, CMS officials explained that under the Federally Qualified Health Center Advanced Primary Care Practice model, participating health centers will be provided with feedback reports on a quarterly basis. According to officials, these reports will describe how each participant is performing relative to others

[40]CMS plans to establish a working group to address cases where the impact of a model is unclear, for example where the cost or quality measures are not statistically significant. In certain cases they may request additional time to test the model.

[41]Officials noted, for example, that with the Comprehensive Primary Care Initiative—which tests the effectiveness of enhanced primary care services—they would not expect participating providers to have an impact on cost and quality right away. Therefore, the assessment of cost and quality measures relative to a comparison group would not be started until approximately 9 months after the start date. Considering the time required to capture claims data and the time it takes to evaluate the data, it would be over a year before they would expect to see results. Officials noted that this time frame will vary by model as some may produce results faster than others.

with respect to the model's measures. The reports, officials say, will also include information on differences among participants in how they are delivering care under the model in order to encourage the adoption of more-successful strategies. Officials told us that rapid cycle feedback will generally begin within the first year after testing of a model has started. As of August 1, 2012, the Innovation Center had started rapid cycle feedback for 1 of the 17 models—the Partnership for Patients model.

The Innovation Center's Plans for Evaluating Its Own Performance Include Aggregating Data across Models and Monitoring Implementation of Models

The Innovation Center's plans for evaluating its own performance include aggregating data on cost and quality measures to determine the overall impact of the center. To do this, the Innovation Center will use a set of core measures. The center has identified about 70 core measures, including some of the preliminary cost and quality measures related to the 17 models it was implementing as of March 31, 2012.[42] Because not all core measures will apply to all models, data will be aggregated for groups of models. To conduct this aggregation, the Innovation Center will use statistical techniques, such as meta-analysis. Aggregation will not occur until individual models have been evaluated, but officials said that the Innovation Center has started asking evaluation contractors to consider using the 70 measures when possible.

The Innovation Center's plans for evaluating its performance also include monitoring its progress in implementing models. The Innovation Center has established a project management approach for its models that includes standard milestones—such as "completion of OMB clearance" and "issuance of participant solicitation and application"—that it uses to track the progress of models against target deadlines. In addition, certain data are monitored for each model against specified targets, such as the number of applications submitted and the number of participants selected. Individual milestones and data are summarized across all of the Innovation Center models every 2 weeks. The intended purpose is to allow the center's management to monitor progress across models and to identify and promptly address potential delays. According to CMS officials, the Innovation Center was monitoring the progress of each of the 17 models it was implementing as of March 31, 2012.

[42]While the core measures will be used to determine the Innovation Center's overall performance, their primary purpose is to compare outcomes between models to determine whether some models had more of an impact on a specific measure than others.

Finally, in order to help evaluate its performance, in June 2012, the Innovation Center contracted with a firm to review the Innovation Center's internal operations and how the center operates within the context of CMS's programs overall. The statement of work for this contract identified a number of objectives, including recommending ways to improve the center's organizational structure, revising the center's management policies and procedures, and identifying additional ways to evaluate the Innovation Center's performance on an ongoing basis. To support these objectives, the contract requires the firm to, for example, identify best practices for expanding innovative models of care into ongoing programs such as Medicare and Medicaid. The contract also requires the firm to identify policies and procedures that are missing within the Innovation Center that would improve its performance. The evaluation under this contract is expected to be completed in November 2012.

The Innovation Center Uses a Number of Mechanisms to Coordinate Efforts That Overlap with Other Offices, but Is Still Working on Ways to Make Coordination More Systematic

In our review of models the Innovation Center was implementing as of March 31, 2012, we identified three key examples of overlap with efforts of other CMS offices. While the center uses a number of mechanisms to coordinate with other CMS offices, it is still working on ways to make coordination more systematic.

Some Innovation Center Models Overlap with Efforts of Other CMS Offices

We identified three key examples of Innovation Center models being implemented as of March 31, 2012, that overlap with efforts of other CMS offices, meaning that the efforts share similar goals, engage in similar activities or strategies to achieve these goals, or target similar populations. However, these overlapping efforts also have differences, and CMS officials said they are intended to be complementary to each other. The three key examples we identified are the following:

- *The Innovation Center's Two Accountable Care Organization (ACO) Models and the Center for Medicare's Shared Savings Program.*[43] The Innovation Center is implementing two models—the Pioneer ACO model and the Advance Payment ACO model—that share similar goals with those of the Shared Savings Program, which is required by PPACA and administered nationally by CMS through its Center for Medicare.[44] All three efforts aim to encourage Medicare providers that participate in ACOs to improve the quality of care among the patients they serve, while at the same time reducing Medicare expenditures. In order to achieve these goals, the efforts provide financial incentives for ACOs that meet specified quality of care and cost savings thresholds by allowing them to share in a certain amount of the savings they achieve for the Medicare program.[45] However, the Innovation Center's models and the Shared Savings Program each adopt a different approach to sharing any realized savings.[46] Further, while the Shared Savings Program is open to all eligible ACOs, the models target specific subgroups of ACOs.[47] According to CMS officials, the Innovation Center's ACO models are intended to be complementary to the Shared Savings Program, because they allow CMS to test alternative approaches to the national effort. If these

[43]An ACO refers to a group of providers and suppliers of services, such as hospitals and physicians, that will work together to coordinate care for the patients they serve.

[44]As required by PPACA, the Center for Medicare is implementing the Shared Savings Program to encourage the use of ACOs in Medicare. Pub. L. No. 111-148, §§ 3022, 10307, 124 Stat. 119, 395-399, 940-941. While the Shared Savings Program is a national program within Medicare, a provider's decision to participate in an ACO is voluntary, and Medicare beneficiaries are still able to choose the providers they would like to see regardless of whether they are in an ACO.

[45]In certain cases, ACOs must also agree to share a certain amount of risk for any losses incurred. See 42 C.F.R. § 425.606 (2011).

[46]For example, whereas the Shared Savings Program pays an ACO—and correspondingly its membership of providers and suppliers—after specified quality of care and savings thresholds are met, the Advance Payment model prepays a portion of expected shared savings.

[47]In the case of the Advance Payment model, it targets ACOs that lack the necessary capital to make investments in care coordination, such as hiring new staff or improving information technology systems.

alternative approaches are proven effective, officials explained, they could be incorporated into the Shared Savings Program.[48]

- *The Innovation Center's Medicaid Models and CMCS's State Medicaid Demonstrations*. As of March 31, 2012, the Innovation Center was implementing nine models that share the same broad goal as the state Medicaid section 1115 demonstrations overseen by CMCS[49]—testing new ways of delivering and paying for health care in Medicaid.[50] Despite this similarity, the Innovation Center's models can test delivery and payment approaches across geographic areas and with different types of participants, including directly with providers, while Medicaid demonstrations under CMCS are agreements between CMS and state Medicaid agencies to test approaches within a particular state. According to CMS officials, the Medicaid models and demonstrations are intended to be complementary: the models allow CMS to test the effectiveness of approaches it selects, while the demonstrations are initiated by states on the basis of their own priorities and needs. Further, officials said that while evaluations of Innovation Center models may be able to more-rigorously test effectiveness,[51] state Medicaid demonstrations allow for a larger number of tests to be conducted—according to CMS, there were

[48]According to CMS officials, it is more difficult to implement changes within the Shared Savings Program because, unlike models, the Shared Savings Program must go through the federal rulemaking process. Among other things, the rulemaking process requires CMS to propose changes and a rationale for the changes, seek and consider stakeholder input, review comments, and make final policy decisions.

[49]Of the nine models, three specifically target Medicaid beneficiaries (Incentives for Prevention of Chronic Disease in Medicaid, Strong Start for Mothers and Newborns, and the Medicaid Emergency Psychiatric Demonstration), three target individuals eligible for both Medicare and Medicaid (State Demonstrations to Integrate Care for Medicare-Medicaid Beneficiaries, Initiative to Reduce Hospitalizations Among Nursing Facility Residents, and the Financial Alignment Initiative), and three include Medicaid beneficiaries in addition to other beneficiary types (Partnership for Patients: Hospital Engagement Networks and Other Strategies, Health Care Innovation Awards, and the Comprehensive Primary Care Initiative). See app. I for more information on these models.

[50]While each state administers its Medicaid program within federal requirements established in statute and regulations, section 1115 of the Social Security Act allows the Secretary of HHS to waive certain federal requirements for demonstrations that the Secretary deems likely to promote Medicaid objectives. 42 U.S.C. § 1315.

[51]For example, according to CMS officials, the Innovation Center is able to define necessary sample sizes and comparison groups for its models, which officials said has historically been difficult within the framework of state Medicaid demonstrations for a number of reasons, including that evaluations have generally been state-specific.

approximately 70 active section 1115 demonstrations as of August 2012—and can point to promising approaches that should be considered for further testing.[52]

- *The Innovation Center's Partnership for Patients Model and CCSQ's Quality Improvement Organization (QIO) Program*. The goals of the Innovation Center's Partnership for Patients model—namely reducing the rate of preventable hospital-acquired conditions and 30-day hospital readmissions[53]—are also currently among the many goals of CCSQ's QIO program.[54] In order to achieve these goals, both the Partnership for Patients model and the QIO program contract with organizations—Hospital Engagement Networks (HEN)[55] and QIOs, respectively—to disseminate successful patient safety interventions in hospitals through training and technical assistance.[56] While the two efforts are very similar in this respect, compared to QIOs, the activities of HENs target more hospital-acquired conditions and focus on a

[52]While there were approximately 70 active section 1115 demonstrations as of August 2012, states use these demonstrations for more than testing specific approaches to health care delivery or payment, such as expanding Medicaid coverage to additional individuals in their state.

[53]According to CMS officials, for the purposes of the Partnership for Patients model, hospital-acquired conditions are conditions that a patient acquires while an inpatient in a hospital, such as catheter-associated urinary tract infections or injuries from falls and immobility. The 30-day hospital readmission rate is the rate at which patients discharged from the hospital return within 30 days. While some readmissions are unavoidable, such as those not related to the initial diagnosis, others can be prevented through the use of best practices of care.

[54]The mission of the QIO Program is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries. The QIO Program is required by the Social Security Act. 42 U.S.C. §§ 1320c-1320c-4, 1395y(g). While QIOs currently work on reducing hospital-acquired conditions and readmissions, they also conduct other activities, such as the promotion of immunizations and screenings, and work in more settings than hospitals, such as nursing homes and physicians' offices. There is one QIO for every state as well as the District of Columbia, Puerto Rico, and the U.S. Virgin Islands.

[55]HENs are state, regional, and national hospital system organizations, such as the Health Care Association of New York State and Intermountain Healthcare.

[56]Contracting with HENs is one of multiple strategies the Partnership for Patients model uses to achieve its goals. Other strategies include engaging in other activities within the federal government and developing relationships with external stakeholders.

broader population that includes non-Medicare patients.[57] CMS officials also told us that the work of HENs and QIOs is intended to be complementary and that HENs reinforce and expand on work already being done by QIOs in order to reduce hospital-acquired conditions and 30-day hospital readmissions at a faster rate. While QIOs may have established relationships with certain hospitals in their states, as of September 2012, CMS officials said that HENs had engaged a much wider network of hospitals in patient safety interventions when compared with QIOs—about 4,000 versus just over 800 respectively. Officials said that one reason for this is that HENs focus exclusively on hospitals whereas QIOs are responsible for implementing improvement projects across all settings of care. Additionally, officials said that because hospital system organizations serve as HENs, they can leverage their member hospitals to encourage these hospitals to adopt patient safety interventions.

The Innovation Center Uses a Number of Mechanisms to Coordinate with Other Offices, but Is Still Working on Ways to Make Coordination More Systematic

Over the period of our review, we identified a number of mechanisms the Innovation Center uses to coordinate its work in order to avoid unnecessary duplication in models that overlap with efforts of other CMS offices. In using these mechanisms, the center has engaged in key practices that we identified in prior work as helping enhance and sustain collaboration,[58] such as leveraging resources, establishing compatible policies and procedures, and developing ways to report on results across offices. The mechanisms the Innovation Center uses are the following:

[57]According to CMS, HENs and QIOs target four of the same conditions: catheter-associated urinary tract infections, central line-associated blood stream infections, surgical site infections, and venous thromboembolism (refers to pulmonary embolisms resulting from deep vein thrombosis). However, HENs target an additional five conditions: injuries from falls and immobility, obstetrical adverse events, pressure ulcers, adverse drug events, and ventilator-associated pneumonia. Conversely, QIOs target one additional condition, clostridium difficile infections (refers to infections from a bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon).

[58]These collaboration practices are: (1) defining and articulating a common outcome; (2) establishing mutually reinforcing or joint strategies; (3) identifying and addressing needs by leveraging resources; (4) agreeing on roles and responsibilities; (5) establishing compatible policies, procedures, and other means to operate across agency boundaries; (6) developing mechanisms to monitor, evaluate, and report on results; (7) reinforcing agency accountability for collaborative efforts through agency plans and reports; and (8) reinforcing individual accountability for collaborative efforts through performance management systems. See GAO-06-15.

- *Committees and boards*. The Innovation Center uses a number of committees and boards to coordinate with other offices. For example, CMS officials told us that in deciding whether to select a model for testing, the Innovation Center's Portfolio Management Committee considers other efforts within CMS—as well as more broadly across HHS—that may overlap with the model in order to avoid unnecessary duplication. Officials said that when overlap is identified, the decision to continue with the model is made on a case-by-case basis and involves a determination of whether the model is significantly different from existing efforts. Additionally, members of the Portfolio Management Committee are able to help identify staff in other offices that the Innovation Center might want to invite to work on a model in order to leverage existing agency expertise.[59] In another example, CMS's Enterprise Management Board brings together relevant offices across the agency, such as the Chief Operating Officer, the Office of Acquisition and Grants Management, and the Center for Medicare, early in a model's implementation to determine what needs to be done operationally. To avoid unnecessary duplication, the board considers whether there are existing CMS resources that could be leveraged for the model's infrastructure needs or whether a resource being developed for an Innovation Center model could be shared with other CMS efforts.

- *Model approval process*. According to CMS officials, the process CMS uses to approve Innovation Center models for implementation also allows the center to coordinate with other CMS offices. Officials explained that as part of this process, all CMS offices must have the opportunity to review and comment on the ICIP—a document that contains key information on a proposed model, such as design parameters and cost estimates—before the model is approved by the CMS administrator. Officials said that under CMS policy, the Innovation Center must address these comments. The ICIP contains sections that specifically address issues related to overlap, such as a section on "Synergy with Existing or Planned Initiatives" and a section on "Uniqueness/Innovation." CMS officials said that, as a result, when the ICIP is circulated, if the Innovation Center did not sufficiently

[59]CMS officials told us that staff from other offices are invited to participate on teams for Innovation Center models and initiatives to provide technical support on aspects of models that require specific programmatic knowledge. In certain cases, the idea for a model has originated as much from another office as from the Innovation Center, and in these cases the center jointly sponsors the model with that office.

coordinate with other CMS centers or offices during the initial selection of a model, these offices would have the opportunity to raise any concerns related to unnecessary duplication. After a model is approved by CMS, HHS and OMB also review and approve the ICIP.

- *Multi-office meetings at the staff, director, and agency level*. First, CMS officials said that staff from the Innovation Center meet with staff from other offices to work on efforts that overlap. For example, during planning for its ACO models, the Innovation Center met with the Center for Medicare to establish compatible policies and procedures with the Shared Savings Program, such as developing common scripts for 1-800-MEDICARE call centers and rules for elevating beneficiary or provider questions to these centers for additional review.[60] Additionally, in March 2012, the Innovation Center started meeting with CCSQ every week to discuss coordination between HENs and QIOs in order to prevent unnecessary duplication of effort. Second, CMS officials told us that there is regular coordination between the director of the Innovation Center and certain other CMS centers and offices, through meetings that happen on a weekly, biweekly, or monthly basis.[61] Officials said that, among other things, these meetings are intended to share the results of ongoing efforts and address such issues as making sure policies are compatible across similar efforts. Officials also told us that all CMS offices have weekly issues meetings with the CMS Administrator that other offices involved in an issue being discussed are encouraged to attend.[62] Officials told us that if staff from other CMS offices thought an issue related to overlapping efforts had not been adequately addressed through other coordination mechanisms, these meetings serve as an opportunity for them to raise it.

[60] 1-800-MEDICARE is a nationwide toll-free telephone help line that beneficiaries, their families, and other members of the public can call to ask questions about Medicare.

[61] The Innovation Center's director has one-on-one meetings with, among others, the director of the Center for Medicare, CMCS, the Federal Coordinated Health Care Office, CCSQ, the Office of Information Services, and the Chief Operating Officer. Directors also meet together regularly as a group.

[62] Examples of items discussed during the Innovation Center's meetings include documents that need the Administrator's approval, such as ICIPs, as well as general questions for the administrator regarding model design or implementation. CMS officials said that the Innovation Center's weekly meeting with the Administrator is held jointly with the Federal Coordinated Health Care Office.

- *Liaisons*. Officials told us that staff members in other CMS offices serve as liaisons to the Innovation Center, though they are not formally designated as such.[63] Officials said that these staff members primarily serve as a central point of contact so that there is a systematic way to keep track of coordination across offices. For example, CMCS has a staff member serving as a liaison to the Innovation Center who, among other things, ensures that the Innovation Center's models employ policies and procedures that are compatible with Medicaid program rules.

- *Targeted reviews*. CMS officials said that as part of selecting participants for the Innovation Center's Medicaid models, the Innovation Center works with CMCS, CMS regional offices, and OMB to ensure that the models do not duplicate funding for states that are already being funded to engage in the same activity through a CMCS demonstration. For example, the application for the Strong Start for Mothers and Newborns model—which tests, among other things, the effectiveness of three different approaches to providing enhanced prenatal care to Medicaid beneficiaries—specified that states that were already paying for enhanced prenatal services were not allowed to participate in the model.

While the Innovation Center uses these mechanisms, it is also still working on ways to make its coordination with other offices more systematic. Specifically, CMS officials said that while some of the Innovation Center's coordination mechanisms are formalized through documented policies and procedures, the center is considering the extent to which additional policies and procedures are needed. For example, officials said that while the Enterprise Management Board, which is responsible for addressing how models are coordinated with other CMS efforts operationally, is formally established through a written charter, they have considered whether a similar group that deals with coordination at the policy level needs a more formal structure in place. In another example, the Innovation Center has directed the outside firm that began an evaluation of Innovation Center operations in June 2012 to consider, as part of its statement of work, whether there are any gaps in current

[63]Officials said that directors have assigned staff within their office to serve as liaisons to the Innovation Center when it was determined that their offices were going to have ongoing coordination with the center.

center policies and procedures—including those related to coordination with other offices—and to propose solutions to those gaps.

The Innovation Center is also currently developing a process to ensure that CMS does not pay for the same service under both HEN and QIO contracts. Officials said that CMS recognizes there are areas of overlap between HENs and QIOs and that they made an explicit decision to include overlapping activities in HEN and QIO statements of work, because, among other things, the nature of trying to reduce hospital-acquired conditions and readmissions requires multiple entities working from different perspectives in a reinforcing manner. Although the HEN and QIO contractors were originally told to work out areas of overlap locally, largely because of questions asked during our review, officials recognized the need for a more-formal process to ensure coordination was working in practice. CMS officials said that a review of the 26 HEN contracts is under way to identify if any unnecessary duplication of effort has occurred—that is, whether HENs and QIOs are conducting the same activities in the same hospital.[64] Officials noted that the review process has evolved and may continue to evolve over time, in part because of the size of the review—which includes reviewing HENs' activities in approximately 4,000 hospitals—and in part because the Innovation Center has not conducted this type of review previously. CMS officials said that they will take steps, including potentially modifying HEN or QIO contract language, to eliminate any unnecessary duplication of effort that the review identifies and to document how this duplication was addressed.

Finally, officials noted that CMS is in the process of developing a centralized database, which may also help the Innovation Center make its coordination more systematic. Among other things, officials said that the database is intended to help prevent duplicative payments to providers that participate in CMS efforts involving incentive payments for meeting specified quality of care and cost savings thresholds, such as the Innovation Center's ACO models and the Center for Medicare's Shared Savings Program. Specifically, officials said that the database is intended to track which beneficiaries are participating in different efforts across

[64]For example, officials said that because both have been asked to work on reducing central line-associated blood stream infections, it is conceivable that HENs and QIOs could be providing the same technical assistance on reducing this type of infection in the same hospitals.

CMS to help ensure that beneficiaries are not counted twice for the purposes of calculating incentive payments. While officials reported that the database initially became operational in June 2012, they also said that they are currently working on significant system upgrades that are expected in September 2012.

Conclusions

The Innovation Center became operational in November 2010 and is still in the early stages of implementing its first models, with much work—particularly evaluation activities—to be done in coming years. As of March 31, 2012, the Innovation Center had announced 17 models, covering a variety of topics, to test new approaches in health care delivery and payment. In addition, the Innovation Center has developed preliminary evaluation plans for each of the 17 models, although at the time of our review, most still needed to be finalized, and it may take as long as 3-5 years until the evaluations begin to produce results. With spending on health care in the United States continuing to increase, and an appropriation of $10 billion every 10 years, it is important that the Innovation Center continue the testing of its models and conduct evaluations as planned in order for CMS to determine the extent to which the new approaches are able to reduce costs and improve quality of care.

At the time of our review, we identified three key examples of Innovation Center models that overlap with efforts being conducted by other offices within CMS. As the Innovation Center and other CMS offices work in similar areas—namely paying for and delivering health care to Medicare and Medicaid beneficiaries—there likely will be additional efforts that overlap as the center continues to build its portfolio of models and initiatives. We encourage these efforts to the extent that they are complementary, well coordinated, and do not result in unnecessary duplication. However, our review also suggests that while the Innovation Center has taken steps to coordinate with other offices, it still has work to do in making this coordination more systematic. For example, the Innovation Center is considering whether additional policies and procedures are needed to coordinate its efforts with other offices, and it will be important for the center to continue to determine the extent to which this is necessary, particularly as it considers the results of the evaluation by an outside firm. In addition, the Innovation Center is still implementing a process to ensure that CMS does not make payments for duplicative services under HEN contracts in its Partnership for Patients model—one of its first and most expensive models to date—and QIO contracts. Given the significance of the Innovation Center's work, and the amount of money involved in its operation, having appropriate and well-

documented coordination mechanisms in place will be an important step going forward to help ensure that resources are used most efficiently and any overlapping efforts do not become unnecessarily duplicative.

Recommendations for Executive Action

In order to ensure the efficient use of federal resources, we recommend that the Administrator of CMS direct the Innovation Center to expeditiously complete implementation of its process to review and eliminate any areas of unnecessary duplication in the services being provided by HENs and QIOs in hospitals.

Agency Comments and Our Evaluation

We provided a draft of this report to HHS for review and comment. In its written comments, reproduced in appendix III, HHS agreed with our recommendation and provided general comments. In addition, on October 26, 2012, the Innovation Center's Deputy Director for Operations provided oral technical comments that were incorporated, as appropriate.

In its written comments, HHS stated that it concurred with our recommendation to expeditiously complete implementation of its process to review and eliminate any areas of unnecessary duplication in the services being provided by HENs and QIOs. HHS described the steps underway to identify and eliminate any duplication of effort, including (1) having Contracting Officer Representatives assess whether there are areas of duplication that require further review and recommend appropriate actions for each contract and (2) if appropriate, putting in place acceptable mitigation strategies, issuing technical direction, or modifying the appropriate contract to eliminate the duplication of effort. HHS stated that it anticipates completing these steps by December 31, 2012, and has monitoring plans in place to assess future changes in the work plans of QIOs and HENs to avoid future duplication.

In its written comments, HHS also stated that only one of the three key examples of overlap cited in the report—the HEN and QIO example—poses a risk of duplicative effort. We agree, and the recommendation we make focuses on this example. The other two key examples we described in our report are overlapping in that they share similar goals, engage in similar activities or strategies to achieve these goals, or target similar populations. We noted that these efforts have important differences and that CMS officials said the efforts were intended to be complementary to each other. Because the Innovation Center and other CMS offices work in similar areas—namely paying for and delivering health care to Medicare and Medicaid beneficiaries—we observed that there will likely be efforts

that overlap. As we reported, we encourage these efforts to the extent that they are complementary, well coordinated, and do not result in unnecessary duplication.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of HHS, the Administrator of CMS, and other interested parties. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or at kohnl@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix IV.

Linda T. Kohn
Director, Health Care

Appendix I: Models Initiated by the Innovation Center as of March 31, 2012, in Order of Start Date

Type of participants	Estimated number and type of beneficiaries affected[a]	Start date of testing and evaluation period	Length of testing and evaluation period	Authorizing section of PPACA[b]	Total funding in millions of dollars (lifetime of model)[c]
State Demonstrations to Integrate Care for Medicare-Medicaid Beneficiaries—Supports state Medicaid programs in designing new approaches to service delivery and financing in order to integrate care for Medicare-Medicaid beneficiaries. This program will enable states to participate in the Financial Alignment Model (see below), which will enroll beneficiaries in 2013.					
State Medicaid programs	Not applicable	4/14/11	18 months for design	3021	$131
Incentives for Prevention of Chronic Diseases in Medicaid—Tests the impact of providing incentives to Medicaid beneficiaries to participate in prevention programs such as those that address tobacco cessation, controlling or reducing weight, lowering cholesterol, lowering blood pressure, and avoiding the onset of diabetes.					
State Medicaid programs	Not available at the time of our review	9/13/11	5 years	4108[d]	100[e]
Federally Qualified Health Center Advanced Primary Care Practice—Tests the effect of the advanced primary care practice model—commonly referred to as the patient-centered medical home—in improving care, promoting health, and reducing the cost of care provided to Medicare beneficiaries by Federally Qualified Health Centers. Federally Qualified Health Centers are health centers that have received a “Federally Qualified Health Center” designation from the Centers for Medicare & Medicaid Services (CMS) and provide comprehensive community-based primary and preventive care services in medically underserved areas or to medically underserved populations.					
Federally Qualified Health Centers (must have at least 200 Medicare fee-for-service beneficiaries)	202,000 Medicare beneficiaries	11/1/11	3 years	3021	57.2
Partnership for Patients: Community Based Care Transitions—Tests approaches to reduce unnecessary hospital readmissions by improving the transition of Medicare beneficiaries from the inpatient hospital setting to home or other care settings.					
Hospitals with high readmission rates that partner with community-based organizations that provide care transition services	275,000 Medicare beneficiaries	11/18/11	5 years	3026[f]	500[g]
Partnership for Patients: Hospital Engagement Networks and Other Strategies—Tests the effectiveness of multiple strategies to reduce preventable hospital-acquired conditions—conditions that a patient acquires while an inpatient in the hospital, such as catheter-associated urinary tract infections or injuries from falls—and 30-day hospital readmissions. One example of a strategy used by the Partnership for Patients is contracting with Hospital Engagement Networks—which are state, regional, and national hospital system organizations—to disseminate successful patient safety interventions in hospitals through training and technical assistance.					
Networks of hospitals and their hospital members	While Medicare and Medicaid beneficiaries will be affected, this model targets all patients receiving related services in participating hospitals	12/9/11	2 years with 1 option year	3021	513

Title and description: each model's title and description appears as a full-width row above its details.

Type of participants	Estimated number and type of beneficiaries affected[a]	Start date of testing and evaluation period	Length of testing and evaluation period	Authorizing section of PPACA[b]	Total funding in millions of dollars (lifetime of model)[c]
Title and description					
Pioneer Accountable Care Organization (ACO) Model—Tests the effectiveness of allowing experienced ACOs to take on financial risk in improving quality and lowering costs for all of their Medicare patients. An ACO refers to a group of providers and suppliers of services, such as hospitals and physicians, that work together to coordinate care for the patients they serve.					
ACOs with at least 15,000 Medicare fee-for-service beneficiaries (or at least 5,000 Medicare beneficiaries in the case of rural areas)	750,000 Medicare beneficiaries	1/1/12	3 years with optional 2-year extension	3021	77.3
Treatment of Certain Complex Diagnostic Laboratory Tests—Tests the effect of making separate payments for certain complex diagnostic laboratory tests on access to care, quality of care, health outcomes, and expenditures.					
Clinical laboratories performing certain complex tests	Not applicable	1/1/12	2 years	3113[h]	105[i]
Strong Start for Mothers and Newborns—Tests two strategies to improve outcomes for newborns and pregnant women: (1) shared learning and diffusion activities to reduce the rate of early elective deliveries among pregnant women and (2) enhanced prenatal care to reduce preterm births (less than 37 weeks) in women covered by Medicaid. Each of these strategies addresses three different approaches to achieving these goals.					
Providers of obstetric care, hospitals, state Medicaid programs, Medicaid managed care organizations	Strategy 1: This model targets all patients receiving related services Strategy 2: 90,000 Medicaid beneficiaries	2/8/12	Strategy 1: 2 years; Strategy 2: 4 years	3021	99.2
Advance Payment ACO Model—Tests the effect of prepayment of shared savings to support ACO infrastructure development and care coordination on quality and costs of care for Medicare beneficiaries.					
Small physician-led or rural organizations participating in the Medicare Shared Savings Program	650,000 Medicare beneficiaries	4/1/12	3 years	3021	177.1
Independence at Home Demonstration—Tests the effectiveness of delivering an expanded scope of primary care services in a home setting on improving care for Medicare beneficiaries with multiple chronic conditions.					
Physician practices with at least 200 high-need beneficiaries	10,000 Medicare beneficiaries	6/1/12	3 years	3024[j]	30[k]
Health Care Innovation Awards—Tests a variety of innovative approaches to paying for and delivering care that have a focus on those that will train and deploy the health care workforce to support these innovations.					
Diverse set of participants	Not available at the time of our review	7/1/12	3 years	3021	931.2
Medicaid Emergency Psychiatric Demonstration—Tests whether Medicaid can support higher quality care at lower cost by reimbursing private psychiatric hospitals for certain services for which Medicaid reimbursement has historically been unavailable.					
State Medicaid programs	Not available at the time of our review	7/1/12	3 years	2707[l]	75[m]

Title and description					
Type of participants	Estimated number and type of beneficiaries affected[a]	Start date of testing and evaluation period	Length of testing and evaluation period	Authorizing section of PPACA[b]	Total funding in millions of dollars (lifetime of model)[c]
Graduate Nurse Education Demonstration—Tests the effect of offsetting the costs of clinical training for Advanced Practice Registered Nurses on the availability of graduate nursing students enrolled in APRN training programs.					
Hospitals, schools of nursing, and non-hospital-based community-based care settings	Not applicable	9/1/12	4 years	5509[n]	200[o]
Comprehensive Primary Care Initiative—Tests the impact of enhanced primary care services, including care coordination, prevention, and 24-hour access for Medicare and Medicaid beneficiaries.					
Commercial and state health plans and primary care physician practices in seven selected localities across the country.	Up to 315,000 Medicare and 16,000 Medicaid beneficiaries	10/1/12	4 years	3021	322.1
Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents—Tests partnerships between independent organizations and long-stay nursing facilities to enhance on-site services to reduce inpatient hospitalizations for Medicare-Medicaid beneficiaries.					
Organizations that partner with states and nursing facilities to provide enhanced care coordination	Not available at the time of our review	Fall 2012	4 years	3021	158
Bundled Payment for Care Improvement—Tests the effect of different payment approaches that link payments for multiple services received by patients during an episode of care, including hospitalization and posthospital services, on the coordination of patient care. Four different models of bundling will be tested, but information on models 2 through 4 was not available at the time of our review.					
Providers such as hospitals, physician group practices, and health systems	Model 1: 389,000 Medicare fee-for-service beneficiaries	12/1/12	3 years with possible 2-year extension	3021	119.4
Financial Alignment Initiative—Tests two approaches to integrating the service delivery and financing of the Medicare and Medicaid programs to better coordinate care for Medicare-Medicaid beneficiaries: a capitated approach where a state, CMS, and a health plan enter into a three-way contract to provide comprehensive coordinated care; and a managed fee-for-service approach where a state and CMS enter into an agreement where the state would be eligible to benefit from savings resulting from its initiatives designed to improve quality and reduce costs.					
State Medicaid programs	Up to 2 million Medicare-Medicaid beneficiaries	2013	3 years	3021	73

Source: GAO analysis of CMS data.

Notes: While this report generally uses the term “models” when discussing the Center for Medicare and Medicaid Innovation’s (Innovation Center) efforts to test new approaches to health care delivery and payment, in some cases the Innovation Center’s title for a model may include the words “demonstration” or “initiative.”

[a]Beneficiaries affected may include individuals enrolled in Medicare, Medicaid, or both programs simultaneously, in which case they are referred to as Medicare-Medicaid beneficiaries. Medicare is the federal health insurance program for persons aged 65 or over, individuals under the age of 65 with certain disabilities, and individuals with end-stage renal disease. Medicaid is a joint federal-state program that finances health care for certain categories of low-income individuals. The State Children’s Health Insurance Program is a federal-state program that provides health care coverage to children 18 years of age and younger living in low-income families whose incomes exceed the

eligibility requirement for Medicaid. For this report we use the term “Medicaid” to include both Medicaid and the State Children’s Health Insurance Program.

[b]Section 3021 of the Patient Protection and Affordable Care Act (PPACA) established the Innovation Center and authorized the selection of models to test using the funds appropriated to it in that section. Pub. L. No. 111-148, §§ 3021, 10306, 124 Stat. 119, 389-395, 939-940 (codified at 42 U.S.C. § 1315a). There are also models specifically required in other PPACA provisions that the Innovation Center is responsible for implementing.

[c]Section 3021 appropriated $10 billion for Innovation Center activities for the period of fiscal years 2011 through 2019 and $10 billion per 10-year fiscal period beginning in 2020. These amounts are to remain available until expended. For models selected by the Innovation Center, the center obtains approval from CMS, the Department of Health and Human Services, and the Office of Management and Budget for the amount it expects will be required to test and evaluate the models, and this funding comes from the Innovation Center’s PPACA appropriation. For models specifically required by other PPACA provisions, the funding amount is the amount appropriated in each PPACA provision.

[d]Section 4108 requires the award of grants to states to test approaches that may encourage behavior modification and determine scalable solutions by providing incentives to Medicaid beneficiaries. § 4108, 124 Stat. at 561-564 (codified at 42 U.S.C. §1396a note).

[e]Section 4108 appropriated $100 million for a 5-year period beginning on January 1, 2011. The amount appropriated is to remain available until expended.

[f]Section 3026 requires the implementation of a model that tests whether partnerships between high-admission-rate hospitals and community-based service organizations can improve transition care services for high-risk Medicare beneficiaries § 3026, 124 Stat. at 413 - 415 (codified at 42 U.S.C. § 1395b-1 note).

[g]Section 3026 requires the transfer of $500 million from Medicare trust funds for the period of fiscal years 2011 through 2015. The amount transferred is to remain available until expended.

[h]Section 3113 requires CMS to develop appropriate payment rates for the tests included in this demonstration. § 3113, 124 Stat. at 422-423 (codified at 42 U.S.C. § 1395l note).

[i]Section 3113 requires the transfer of $5 million from the Medicare Part B trust fund for administering the demonstration. The amount transferred is to remain available until expended. Payments under the demonstration are to be made from Medicare Part B funds and may not exceed $100 million.

[j]Section 3024 requires CMS to conduct a demonstration to test a payment and service-delivery model that utilizes physician- and nurse practitioner–directed home-based primary care teams for reducing expenditures and improving the health outcomes of certain Medicare beneficiaries. §§ 3204, 10308(b)(2). 124 Stat. at 404-408, 942 (codified at 42 U.S.C. § 1395cc-5).

[k]Section 3024 requires the transfer of $5 million from Medicare trust funds for each of fiscal years 2010 through 2015. The amounts transferred are to remain available until expended.

[l]Section 2707 requires CMS to select states to participate in the demonstration project on a competitive basis. §2707, 124 Stat. at 326-328 (codified at 42 U.S.C. § 1396a note).

[m]Section 2707 appropriated $75 million for fiscal year 2011. The amount appropriated is to remain available through December 31, 2015.

[n]Section 5509 requires CMS to conduct a demonstration under which eligible hospitals receive payment for their reasonable costs for the provision of qualified clinical training to advanced practice nurses. § 5509, 124 Stat. at 674-676 (codified at 42 U.S.C § 1395ww note).

[o]Section 5509 appropriated $50 million for each of fiscal years 2012 through 2015. The amount appropriated is to remain available until expended.

Appendix II: Innovation Center: Steps in Process for Implementing Models

Planning and development	
Solicit ideas for new models and select which models to develop[a]	• The Center for Medicare and Medicaid Innovation (Innovation Center) solicits and receives ideas for different payment and care delivery approaches through "Listening Sessions" and through its web-based idea-submission tool.[b] • The Innovation Center reviews ideas that have been submitted and evaluates them with respect to their potential to meet its primary goals of better health care, better health, and reduced costs. It reviews ideas against "Portfolio Criteria" that were created to guide the Innovation Center in developing a portfolio of models that address a range of populations, issues, problems, and solutions. • Examples of these criteria include: having the greatest potential impact on Medicare and Medicaid beneficiaries and improving how care is delivered nationally; focusing on health conditions that offer the greatest opportunity to improve care and reduce costs; and meeting the needs of the most vulnerable and addressing disparities in care.[c,d] • As part of this selection process, the Innovation Center reviews model types suggested in the Patient Protection and Affordable Care Act (PPACA) provision that established the center, and seeks input from across the Centers for Medicare & Medicaid Services (CMS), the Department of Health and Human Services (HHS), and other federal partners and from an array of external stakeholders.

Develop an Innovation Center Investment Proposal (ICIP)	• Once the Innovation Center identifies a payment and care delivery model that shows promise, it develops an ICIP, which typically includes
	    • a proposed design for the model including the size and scope of testing, the population and programs involved, and duration;
	    • a summary of prior evidence and supporting research;
	    • a preliminary evaluation plan including research questions, proposed measures related to cost and quality, and discussion of the model's expected impact; and
	    • an implementation plan, including the application and selection process, an analysis of whether the model overlaps or complements other initiatives, and an analysis of the potential for expansion of the model.
	• The Innovation Center prepares separate documents for approval that are related to funding requests and solicitations associated with the model.

Obtain approval from CMS, HHS, and the Office of Management and Budget (OMB) and announce model	• The Innovation Center seeks approval for the model. This includes separate approval processes for the ICIP, for model funding, and for any solicitations that would be issued to potential participants. • The approval process includes a sequence of reviews within CMS, within HHS, and finally with OMB. During these reviews, modifications may be made on the basis of input from individuals in other CMS centers and offices, in other related HHS programs, and from OMB. • Once the ICIP is approved, the Innovation Center issues an announcement and other information about the model to the public.

Planning and development	
Solicit, select, and establish agreements with participants	• The Innovation Center issues information about how to apply for participation in the model, including information about which types of providers or organizations are eligible to participate, the process for submitting applications, and the selection process. The Innovation Center may also organize webinars or learning sessions open to the public and interested participants to share information and answer questions. • Innovation Center models vary by the type of participant that is involved—for example, physician group practices, health plans, and state Medicaid programs. • Models also vary in terms of the type of agreement that is established with participants, for example, whether it is a grant, a cooperative agreement, a contract, or a provider agreement. • The selection process for participants is generally competitive. The criteria used in the selection process may vary by model. For example, selection criteria may include such factors as organizational capabilities and plans for ensuring quality of care. In other cases, eligible participants may be selected in order to achieve a mix and balance of certain characteristics for evaluation purposes, for example geographic location (urban, rural) and whether the participant uses electronic health records.
Solicit and select contractors for testing and evaluating model	• The Innovation Center solicits and hires contractors to evaluate the model. Applicants are asked to propose specific evaluation approaches to the preliminary evaluation plans that the Innovation Center has identified. Contractors are selected through a competitive process. Once a contractor is selected, it works with the Innovation Center to complete a design phase and reach agreement on the final evaluation plan for the model. • The Innovation Center also engages contractors for other purposes that are part of implementation, such as data collection and provider recruitment.
Testing and evaluation	
Conduct test of model	• The changes that the model is testing—for example, changes to health care delivery or payment—are put into effect by CMS and by participants. • The testing period for Innovation Center models is typically set for 3 to 5 years. However, evaluation monitoring may indicate that the model should be modified, terminated, or expanded before this period ends (see below). The Innovation Center may choose to shorten the test period for a model for such reasons.
Conduct evaluation of model to assess its impact on cost and quality	• Data are collected for cost and quality measures. Using a variety of statistical techniques, these data are generally compared to data for a comparison group representing patients or providers that are not participating in the model to determine the model's impact on cost and quality. When comparison groups are not possible, data for model participants are compared to "baseline" data that represent a period prior to the test period. Qualitative information on the different strategies participants may use to deliver care under each model is also collected and analyzed. • During the testing period information collected is shared on a regular basis with participants. The purpose of this "rapid cycle" feedback is to provide timely information so that participants can make improvements during the testing period.

Testing and evaluation	
Determine whether to terminate, modify, or recommend expanding model	• The Innovation Center plans to regularly review each model's impact on the quality and cost of care to determine whether the payment or delivery approach is successful and should be recommended for expansion into the Medicare or Medicaid program. • If the Innovation Center seeks to expand a program, the CMS Office of the Actuary must certify that the model would either (1) result in cost savings or (2) not result in any increase in costs if implemented on a broader scale within Medicare or Medicaid, or both.

Source: GAO analysis of CMS information.

Notes: The Innovation Center's process for implementing models includes interaction with several government organizations, including HHS, which oversees a wide range of federal health programs; CMS, which is the agency within HHS that administers Medicare and Medicaid; and OMB, which assists the President in overseeing the preparation of the federal budget and in supervising its administration in executive agencies.

[a]The step of soliciting ideas applies to those models selected by the Innovation Center under the PPACA provision establishing the center. Generally, it does not apply to models the center implements that are specifically required by other provisions of law.

[b]A series of Listening Sessions was held in 2010, and transcripts of these sessions are available at http://www.innovations.cms.gov/community/webinars-and-forums/2010/index.html (accessed Sept. 13, 2012).

[c]Medicare is the federal health insurance program for persons aged 65 or over, individuals under the age of 65 with certain disabilities, and individuals with end-stage renal disease. Medicaid is a joint federal-state program that finances health care for certain categories of low-income individuals. The State Children's Health Insurance Program is a federal-state program that provides health care coverage to children 18 years of age and younger living in low-income families whose incomes exceed the eligibility requirement for Medicaid. For this report we use the term "Medicaid" to include both Medicaid and the State Children's Health Insurance Program.

[d]The Innovation Center's criteria can be found at: http://www.innovations.cms.gov/about/our-portfolio-criteria/index.html (accessed Sept. 13, 2012).

Appendix III: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

NOV 2 2012

Linda T. Kohn
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Kohn:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "CMS INNOVATION CENTER: Early Implementation Efforts Suggest Need for Additional Actions to Help Ensure Coordination With Other CMS Offices" (GAO-13-12).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "CMS INNOVATION CENTER: EARLY IMPLEMENTATION EFFORTS SUGGEST NEED FOR ADDITIONAL ACTIONS TO HELP ENSURE COORDINATION WITH OTHER CMS OFFICES (GAO-13-12)

The Department appreciates the opportunity to comment on this report. The Patient Protection and Affordable Care Act (PPACA) created the Center for Medicare and Medicaid Innovation (Innovation Center). The purpose of the Innovation Center is to test innovative payment and service delivery models to reduce expenditures in Medicare, Medicaid and the Children's Health Insurance Program (CHIP) while preserving or enhancing the quality of care. GAO was asked to review the implementation of the Innovation Center. In this report, GAO:

- Describes the Center's activities, funding, organization, and staffing as of March 31, 2012;
- Describes the Center's plans for evaluating its models and its own performance; and
- Examines whether efforts of the Center overlap with those of other Centers for Medicare & Medicaid Services (CMS) offices and how the Center coordinates with other offices.

GAO found that the Innovation Center is in the early stages of implementing its first models with much work, particularly on evaluations, to be done in the coming years. GAO noted it is important that the Innovation Center continue testing its models and conduct evaluations to determine the extent to which new approaches are able to reduce costs and improve quality of care. GAO identified a few examples of Innovation Center models that overlap with efforts being conducted in other offices within CMS and the mechanisms the Innovation Center uses to coordinate its work in order to avoid unnecessary duplication.

GAO issued one recommendation for executive action. HHS concurs with this recommendation and are taking steps to address it, as described further below.

GAO Recommendation

The Administrator of CMS should direct the Innovation Center to expeditiously complete implementation of its process to review and eliminate any areas of unnecessary duplication in the services being provided by Hospital Engagement Networks (HENs) and Quality Improvement Organizations (QIOs) in hospitals.

HHS Response

HHS concurs with GAO's recommendation and is committed to identifying and eliminating duplication of effort. However, HHS believes that only one of the three examples cited poses a genuine risk of duplicative effort and we are working to address that concern. Our view on each example of potential overlap is described in detail below.

- CMMI ACO Models / MSSP: The draft GAO report expresses concern about duplication between the Medicare Shared Savings Program (MSSP) and CMMI's two ACO models. We do not believe this concern is justified. The two models (Pioneer ACOs and Advance Payment ACOs) were carefully and explicitly designed to be complementary to MSSP.

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "CMS INNOVATION CENTER: EARLY IMPLEMENTATION EFFORTS SUGGEST NEED FOR ADDITIONAL ACTIONS TO HELP ENSURE COORDINATION WITH OTHER CMS OFFICES (GAO-13-12)

The Pioneer ACO model is a discrete initiative; as such, providers who participate in a Pioneer ACO are not permitted to also participate in MSSP. Therefore, there is no potential for overlap. Conversely, the Advance Payment model is a tool to allow certain ACOs to be successful, within the context of the MSSP program. Accordingly, all participants in the Advance Payment ACO initiative are also required to participate in MSSP. As such, the two programs are fully aligned and work in conjunction with each other.

- Innovation Center Medicaid Models and CMCS State Medicaid Demonstrations: The draft GAO report expresses concern about duplication between Innovation Center Models and §1115 State Medicaid Waivers. Here too, we believe this concern is not justified. We note that the coexistence of these two authorities is simply a statutory fact, and in no sense the consequence of CMMI policy decisions or other actions. Moreover, there are very fundamental differences between the two authorities: §1115A (CMMI) models are initiated by CMS, are focused on payment and delivery reforms, are not required to be budget neutral during the testing phase, and can span multiple States and payer types, although their ability to waive Medicaid provisions is limited. By contrast, §1115 (CMCS) waivers are initiated by States, can go beyond payment/delivery reforms to include coverage/service expansions, must be budget neutral, and are limited in scope to Medicaid within a single State, although within this limited context they have broad latitude. Given these fairly fundamental differences, we think the likelihood of overlap is extremely low, although a §1115 waiver and an Innovation Center model may sometimes work in a complementary fashion. We believe it is telling that, of the nine CMMI models cited as potentially overlapping with §1115 authority, all either include other (non-Medicaid) payers or are national in scope (and most are both). As such, none of these models could reasonably have been pursued through §1115 authority. Additionally, two of these models (Incentives for Prevention of Chronic Disease in Medicaid and the Medicaid Emergency Psychiatric Demonstration) were specifically authorized and appropriated through the ACA, so we note that any potential for duplication with existing CMCS efforts would be purely the result of statutory requirements.

- Partnership for Patients Model and QIOs: The Partnership for Patients within the Innovation Center and the Center for Clinical Standards and Quality (CCSQ) are both charged to work collaboratively to reduce hospital acquired conditions and readmissions. CMS designed the Partnership for Patients initiative to maximize the respective strengths of the HENs and the QIOs. For example, QIOs have highly specialized expertise in data collection and analysis, while HENs (which are mostly hospital systems and state or national hospital associations) have strong relationships with hospital administrators and can capitalize on these relationships. It is CMS's intention that QIOs and HENs capitalize on these and other distinct strengths in supporting the quality improvement work of hospitals.

  When the Partnership for Patients awarded the HEN contracts in December 2011, the Secretary specifically charged QIOs and HENs, and their accountable CMS program offices, to collaborate to maximize the teamwork and synergy among these programs. To

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "CMS INNOVATION CENTER: EARLY IMPLEMENTATION EFFORTS SUGGEST NEED FOR ADDITIONAL ACTIONS TO HELP ENSURE COORDINATION WITH OTHER CMS OFFICES (GAO-13-12)

ensure appropriate management and oversight of both initiatives, the Innovation Center and CCSQ have been analyzing the activities of the HENs and QIOs as they relate to one another in the areas of hospital acquired conditions and hospital readmissions.

CMS has put steps into place to identify and eliminate any duplication of effort between the HENs and the QIOs. Both the steps that have previously been implemented and those that are underway within CMS are as follows:

1. Teams were formed in March 2012 in the Innovation Center, CCSQ, and the CMS Office of Acquisition and Grants Management (OAGM) to collaborate, prevent duplication, and continuously monitor the effort. Regular weekly team meetings were established to ensure clear communication and teamwork.
2. QIOs and HENs have been instructed by their accountable CMS Contracting Officer Representatives (CORs) to develop clear plans that delineate their accountabilities and arrangements they may have worked out locally to ensure there is no duplication of effort. In addition, the CORs have collected information from the QIOs and HENs and are conducting an independent assessment of whether there are areas of duplication that require further review. If duplication is identified, the CORs make recommendations to OAGM on the appropriate action for each contract.
3. OAGM assesses the CORs' recommendations to make final determinations whether to accept or modify any recommended actions for each contract. If any potential duplication is identified, CMS will work with the contractors to implement the following actions, as appropriate: (1) Put in place an acceptable mitigation strategy; (2) Issue the appropriate technical direction; or (3) Modify the appropriate contract (either the HEN or QIO, or both) to eliminate the duplication of effort.

CMS anticipates completing the work described above by December 31, 2012. In addition, monitoring plans are in place for the CORs to regularly assess future changes in the work plans of QIOs and HENs and the relationships of QIOs and HENs in the field to avoid future duplication.

Testing new payment and service delivery models for Medicare, Medicaid and CHIP is one of CMS's key priorities. Through such testing we can identify ways to improve health and health care and reduce costs through improvement.

Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

Linda T. Kohn, (202) 512-7114 or kohnl@gao.gov

Staff Acknowledgments

In addition to the contact named above, Kristi Peterson, Assistant Director; Krister Friday; Mary Giffin; Samantha Poppe; Rachel Svoboda; and Jennifer Whitworth made key contributions to this report.

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