Reports and Research

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May 23, 2012 Board Meeting

Covered California
www.coveredca.com





CUT THE COST of Health Insurance

A new tax credit helps
lower- and middle-income families

1 Do I Qualify?

If you answer **NO** to ALL of these questions, you may qualify:

1. **Does your employer offer health insurance?** ☐ YES ☐ NO

2. **Do you receive Medicare?** ☐ YES ☐ NO

3. **Does your family make *more* than the yearly income below?** ☐ YES ☐ NO

FAMILY SIZE	YEARLY INCOME
1	$45,960
2	$62,040
3	$78,120
4	$94,200
5	$110,280
6	$126,360

If your income is near these amounts, you may still qualify.

2 How Does the New Tax Credit Work?

What is this tax credit?

The Health Premium Tax Credit reduces the total amount of tax you owe the IRS. If you don't owe, you can get a bigger refund. You get the tax credit to help cut the cost of your health insurance.

Can I use my tax credit for any health plan?

NO. You MUST buy your health insurance from:

Covered California
1-888-975-1142
www.coveredca.com

This new marketplace offers a wide variety of health plans with good benefits. All plans cover prescriptions, hospital stays, doctor visits and more. If you buy different coverage, you won't get the tax credit help.

How much help will I get?

The amount depends on your family income and your family size. Lower income families get the most help.

When does it start?

The tax credit begins with insurance that starts January 1, 2014 — or later.

3 Two Ways to Take the Tax Credit

Take It Now!

October 2013 – March 2014	• Sign up for health insurance at **www.coveredca.com** • Tell them you want the tax credit "in advance" • Choose to take all your credit in advance — or just part of it
During 2014	• Pay a lower premium each month in 2014 — and now you are covered
January 2015 – April 2015	• Get a statement from your Health Insurance Marketplace showing how much tax credit you received in 2014 • File your 2014 taxes, including information about tax credit already taken

ADVANTAGE: Lower your health care premium each month!

Jane needs to decide which way works best for her. Either way, she gets the same total tax credit for the year.

"If I take the tax credit now, I lower my monthly premium costs to $60."

Monthly Premium	$300
Monthly Tax Credit	**– $240**
New Monthly Cost	$60

— You Decide!

Take It Later!

October 2013 – March 2014	• Sign up for your health insurance at **www.coveredca.com**
During 2014	• Pay the full premium each month in 2014 — and now you are covered
January 2015 – April 2015	• File your 2014 taxes • Subtract your tax credit from the tax you owe — or get a bigger refund if you don't owe anything

ADVANTAGE: Lower the amount you pay at tax time!

"If I take the same tax credit later, I pay the full $300 premium now but get a bigger refund next April."

Tax Due	$900
Yearly Tax Credit	**– $2,880**
IRS Refund	$1,980

CALL 1-888-975-1142

4 Taking Your Credit Now? Get the

If you take the tax credit in **advance**, changes to your family size or income — or even a new job that offers health insurance — could mean you're getting the wrong amount of tax credit. To make sure you get the right amount, call when you have changes:

Covered California
1-888-975-1142
www.coveredca.com

When can family size change?

- You get married or divorced
- You have a baby
- You no longer claim your child on your tax return

⬇ Family size goes DOWN	Call to recalculate your credit so you won't owe money.
⬆ Family size goes UP	Call so you might get more credit.

When can income change?

- You get a raise
- You lose your job
- You take a salary cut

⬇ Income goes DOWN	Call so you might get more credit.
⬆ Income goes UP	Call to recalculate your credit so you won't owe money.

Remember: It's your responsibility to tell your state's Marketplace!

VISIT www.coveredca.com

Right Tax Credit.

What if your income changes each month?

Talk to your Marketplace about taking a partial credit. Your monthly premiums will still be lower but not as much. By taking the rest at tax time, there is less chance of repayment.

What if your new job offers health insurance?

Call your state's Marketplace. You may no longer be eligible for your tax credit.

AVOID REPAYMENTS!

Claudia and Patrick's story

"In January, we decided to take the tax credit in advance. On August 1, I got a new job that increased our income so we no longer qualified for the tax credit. We forgot to tell our Health Marketplace. At tax time, we had to pay back $2,000."

Tax credit they got over 12 months	$4,800
Amount they should have gotten since credit ended in August	– $2,800
Amount they must pay back	**$2,000**

Remember: You control how much tax credit you use in advance.

CALL 1-888-975-1142

5 How Do I Get Started?

- For details on whether you qualify and how much credit you will get, contact your state's Health Insurance Marketplace:

  www.coveredca.com

  or Call Center

  1-888-975-1142

- Need more advice? Talk to local assistors, such as navigators, brokers or agents who are familiar with this new program at:

  or call

  or visit this local office:

- At tax time, talk to your tax preparer or find free tax preparation help at:

  irs.treasury.gov/freetaxprep

  or call

  1-800-906-9887

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Helping Consumers Understand the New Premium Tax Credit

May 15, 2013

CONDUCTED BY

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POLICY & ACTION FROM CONSUMER REPORTS

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We are also grateful to our key informants who provided the perspective of tax preparers and private insurance enrollment counselors who work with consumers on a daily basis. Our six "experts" were generous with their time and thoughtful in their comments.

About the Authors

Lynn Quincy is a Senior Health Policy Analyst at Consumers Union. Ms. Quincy works on a wide variety of health policy issues, with a particular focus on consumer protections, consumers' health insurance literacy and health insurance reform at the federal and state levels. Ms. Quincy also serves as a consumer expert in several venues, including as a consumer representative with the National Association of Insurance Commissioners. Prior to joining Consumers Union, Ms. Quincy held senior positions with Mathematica Policy Research, Inc., the Institute for Health Policy Solutions and Watson Wyatt Worldwide (now Towers Watson). She holds a master's degree in economics from the University of Maryland.

Susan Kleimann is President of Kleimann Communication Group, Inc. Dr. Kleimann has over 35 years of experience providing technical assistance to both public and private sector organizations. Since founding her company in 1997, Dr. Kleimann has become one of the nation's foremost experts on clear communication, plain language, and information design. Dr. Kleimann's expertise includes policy change, qualitative testing, evaluation, and research-based information. She has also testified before Senate Special Committees and serves as Vice Chair of the U.S. Center for Plain Language, which helped to spearhead the Plain Writing Act of 2010. Prior to founding Kleimann Communication Group, she was the Director of the Document Design Center at the American Institutes for Research.

Barbra Kingsley, Ph.D., a Partner with Kleimann, has nearly 20 years of experience managing high-impact communication studies that seek to transform processes, products and—ultimately—people. Her work sits at the juncture of behavioral sciences, organizational change and leadership, and user-centered design. She helps government agencies make research-based decisions about communication and then implement results widely and effectively. Prior to joining Kleimann, Dr. Kingsley was a research associate in the Document Design Center at the American Institutes for Research.

Kleimann Communication Group is a DC-based research and design firm focused on exploring how information can be made usable for targeted populations.

About the Robert Wood Johnson Foundation

The Robert Wood Johnson Foundation focuses on the pressing health and health care issues facing our country. As the nation's largest philanthropy devoted exclusively to health and health care, the Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, measurable and timely change.

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Executive Summary

Survey data show that the largest barrier to health coverage is difficulty finding a plan that families can afford. Beginning in 2014, the Affordable Care Act (ACA) introduces major reforms, including the start of a new advance payment Premium Tax Credit designed to lower the cost of coverage for qualified families purchasing in the new Health Insurance Marketplaces (exchanges).

While employer-provided coverage receives significant tax preferences, tax credits for individual or non-group health insurance have not been used in a broad way. What's more, the advanceable and refundable features of the new tax credits introduce new elements that most consumers haven't previously encountered. Taken together, these facts raise the possibility that consumer confusion might be a barrier to using this new program to enroll in affordable coverage.

Our Testing

To better understand how consumers will respond to the new tax credits, our study explores consumer responses to a new Premium Tax Credit "explainer" or brochure. Our findings reflect three rounds of consumer testing in Maryland, Oklahoma and Utah.

Our testing showed that the brochure successfully helped participants understand the important issues around the Premium Tax Credit. Specifically, the brochure was able to convey ten important ideas to ensure that consumers could understand sufficiently to apply for the tax credit and to avoid harm. (See "Critical Tax Credit Facts for Consumers.")

Our testing showed that the brochure provided participants with a useable idea of whether they would qualify, and inspired them to take action if they did qualify. Further, participants readily understood the lengthy timeline for the tax credit:

- they knew when the enrollment period began and ended
- they generally understood when the tax credit would apply and when they had to select advance payment
- they understood when they would need to report the tax credit on their taxes

All participants understood the basic differences between the "Take It Now" (in advance) and "Take It Later" (at tax time) options—and were almost evenly divided in which they would choose.

The new brochure was able to convey ten important ideas about the tax credit.

Ten Critical Tax Credit Facts for Consumers

1. This is a tax credit program.
2. It will help you afford health insurance.
3. To participate, you must meet certain requirements. However, both lower and middle-income families can qualify.
4. You can use your tax credit only with insurance purchased from your state's new Health Insurance Marketplace.
5. You can take the tax credit in one of two ways with different benefits:
   - In advance, the tax credit lowers your monthly payments.
   - If not taken in advance, the tax credit lowers the amount of taxes owed or increases your refund at the end of the year.
6. Tax credit does not begin until 2014, but you can apply starting in October 2013.
7. If your income or family size changes, the amount of the final tax credit may change.
8. To ensure that any advance tax credit amounts are correct, you must immediately report income and family size changes to the Marketplace.
9. If you take the tax credit in advance and do not report changes, you may have to pay back overpayments.
10. You can get more information by contacting your state's Health Insurance Marketplace.

The Brochure Results

We wanted to create consumer understanding not just in a testing environment but also in the real world. Participants helped us craft a compelling cover and helped us to understand that—in order to invest in reading the brochure—participants wanted to know three things immediately:

- does the information relate to them (*i.e.*, were they eligible)
- who was the source for the information
- what was the "thing" being described (the tax credit)

To increase the utility of the brochure, we addressed each of these concerns. For instance, we noted on the cover that the program could help middle income families because their default assumption was that it wouldn't apply to them. We also used the first interior page of the brochure to clearly and simply describe

who was eligible, again emphasizing that middle income families might be eligible, which surprised and pleased participants.

Most of our participants told us that they viewed the government as a trusted source for information. In contrast, they questioned the objectivity of information coming from a health plan or related entity, and were less inclined to act on information from these sources. To address this, we included the Marketplace URL on the cover which in most states will have a ".gov" extension and repeated this throughout the brochure. This preference for a government source extended to both the state and the federal government and existed alongside preconceived notions that dealing with a government agency could be difficult and burdensome.

We found it challenging to quickly provide that initial informational anchor to the Premium Tax Credit program. While consumers were familiar with tax credits (even if they didn't know how credits differed from tax deductions), they had little information about the Health Insurance Marketplace. Many thought it might have something to do with private health plans. In part because no major public information campaign has begun to educate consumers about the Marketplaces, participants wanted more information about the Health Insurance Marketplace and what it would do. Until we added text saying that there would be a variety of plans offering good benefits, they assumed only a few plans with limited benefits would be offered in connection with the tax credit.

An important piece of information we wanted to communicate was the possibility of repayment if the tax credit was taken in advance. We tried different approaches to find the balance between conveying the possibility of repayment without discouraging participation by families who would benefit. In fact, most participants believed that repayments were a natural consequence of failing to meet their responsibility to keep the Marketplace apprised of their personal circumstances. While they didn't welcome the burden of reporting changes in family size and income, they felt it was a fair obligation. The idea of taking only a partial credit in advance (which can reduce the possibility of repayment) was more difficult to convey, in light of our goal to keep the brochure short and accessible.

Supplemental Products

In addition to the brochure, we tested two supplemental products: a stand-alone, alternative version of the tax credit time line and a worksheet that "assistors" (like brokers or navigators) would use with consumers.

The worksheet included information that was not in the brochure:

- The amount of tax credit is tied to family size, income and second lowest cost Silver plan

We noted right on the cover that the program could help middle income families.

- Once determined, the tax credit amount is fixed, but can be applied to a variety of plans with the consumer paying the difference.

Participants found the worksheet extremely helpful. They were able to get a concrete idea of what the tax credit would be for their family, something that can't be conveyed in an all-purpose brochure. They could see how the tax credit would be applied across plans with varying premiums, and a "bottom line" comparison between the "Take It Now" and "Take It Later" options.

Not one of our participants had previously heard of the new tax credit. Some had a vague awareness of the ACA, typically based on hearsay and sometimes colored by political views. But even those who were somewhat hostile to the ACA found the information in the Tax Credit brochure helpful. Because we crafted a compelling cover and addressed their top concerns, participants reported they would act on the information in the brochure because it would help their families—regardless of their pre-conceived notions of "Obamacare."

Even those somewhat hostile to the ACA found the information in the Tax Credit brochure helpful.

The tax credit brochure and the supplemental products are in the public domain and available for anyone's use (consumersunion.org/tax_credit_brochure). The report shares our insights about why the brochure worked and shares the lessons learned for enrollment assistors, such as navigators and brokers, and the new health plan Marketplaces.

We recommend that the new brochure or similar materials be widely used to raise consumer awareness of their new benefit. Successful communications will:

- address consumers' key questions first
- provide anchoring information
- use visual aids
- use personal stories
- indicate the "bottom line" import of the information

Our general findings on how to communicate the tax credit should also be incorporated into training curriculums, web-based information and other consumer communications that include information about the tax credit.

Chapter 1. Introduction

> "Nearly three of five (57%) adults who had ever shopped for coverage in the individual market found it very difficult or impossible to find a plan they could afford." *The Commonwealth Fund Biennial Health Insurance Survey, 2007*

Beginning January 1, 2014, the Affordable Care Act (ACA) introduces major health reform changes, including the start of new advance payment premium tax credits. These federal income tax credits will help families afford health coverage being sold in the new Health Insurance Marketplaces. Eligible families must have incomes between 100% to 400% of Federal Poverty Level (FPL) and be ineligible for other forms of coverage.

Research to date suggests that the concepts underlying the Premium Tax Credit may be difficult for consumers to understand.[1] For example, one survey found that only 37 percent of study respondents could correctly respond that a tax credit is deducted from total taxes.[2] Consultation with financial literacy experts and tax preparers also suggested that explaining these new tax credits to consumers may be challenging. Even more, the advanceable and refundable nature of the Premium Tax Credit are new concepts for most consumers, adding another layer of potential complexity.

Yet it remains critical for consumers to fully understand the new tax credit for two reasons:

1. A lack of understanding could be a deterrent to health insurance enrollment.
2. If households take too large a credit in advance, they may owe money to the federal government at the end of the tax year. Many tax credit eligible families have limited savings[3] and this liability may be very difficult for them to afford. Families need to understand this potential liability and the steps they can take to avoid it.

Every state will have call centers, navigators, brokers, agents and others to help consumers understand their new rights and responsibilities under the ACA. However, there appears to be little to guide these "assistors" in terms of

Three of five adults shopping for coverage in the individual market found it very difficult or impossible to find a plan they could afford.

[1]Consumers Union conducted a literature review and contacted some financial literacy experts to understand the current state of knowledge with respect to consumer understanding of tax concepts and best practices in consumer-facing tax "explainers." Please contact Consumers Union for a copy of a memo outlining the results of this scan.

[2] Pitts, R. E. and Wittenbach, J.L. (1981). Tax credits as a means of influencing consumer behavior: The residential energy tax credit. *Journal of Consumer Research.*

[3] See survey of relevant studies in Adams, W., Einav, L., and Levin, J. (2007). Liquidity constraints and imperfect information in subprime lending, *National Bureau of Economic Research Working Paper 13067.*

consumer-tested explanations of the Premium Tax Credit. This study begins to fill this evidence gap.

Study Goals

The overall goal of this study was to develop and test a consumer brochure that explains the new Premium Tax Credit. The brochure is designed to be used by the consumers on their own and also can be used with in-person assistors. Further, findings from testing can inform training curricula for brokers and other assistors, as well as other consumer-facing materials that include a description of the tax credit.

The goals for the brochure were:

- consumers are tempted to pick it up
- the design elements and brevity make them willing to read it
- if they might be eligible, they will take action by contacting their state Health Insurance Marketplace or some other consumer assistor
- they understand basic facts about the tax credit

We also developed and tested two additional items to be used by brokers, navigators and other types of assistors: (1) a standalone timeline as an alternate to the timeline in the brochure and (2) a worksheet to explain the calculation of the tax credit to consumers.

The final versions of all these items (brochure, timeline and worksheet) are in the public domain and available for anyone's use (consumersunion.org/tax_credit_brochure).

Study Approach

The design approach to the brochure and the consumer testing reflect relevant findings from consumer behavior research and our understanding of the critical tax credit facts that consumers need to understand.

How Consumers Process Information

The final brochure reflects eight important research-based assumptions about consumers and how they process information. In fact, design decisions, content order and flow were dictated by these principles which describe how consumers skim documents, assess for relevance to themselves and their preferences for plain language and appealing design.

- **Readers decide quickly if a topic is of interest to them**. Readers need a "hook" to get them to pick up materials. With many choices of

reading materials, the material must use key messages, key words and design to attract attention.[4]

- **Readers don't read; they skim.** Readers look to confirm that a topic is relevant to them. They look at headers, emphatic techniques (such as bolding) and design elements (fonts, color, photos, illustrations) that allow them to capture key information and to confirm the material is relevant to them and that they should continue to expend effort.[5]
- **Readers look for narratives, rather than prose.** Readers often respond to read stories about people who illustrate an abstract concept. The stories make the abstract concrete and allow the reader to integrate information as well as see how it works in the real world.[6]
- **Readers approach a document by asking questions**. They look for answers. If the text fails to answer their questions, readers feel confused. If the text answers their questions, they believe the document is "easy" to understand.[7]
- **Readers think that documents that "look" hard to read *are* hard to read**. Readers react positively to plain language, good design and good information design. When these elements are missing, they assume that the content is difficult to understand.[8]
- **Readers prefer plain language**. Readers need language that reflects their own language patterns, not the technical language of experts. Thus, avoiding technical phrases, such as "advanceable tax credit" or 'refundable tax credit," can help readers more easily understand the information."[9]
- **Readers need to "know" to be able to build meaning.** Readers need to have information they "know"—an informational anchor—so they can add new information and understand it. When they are unfamiliar

Readers don't read; they skim.

[4] McGuire, W.J. (1976). Some internal psychological factors influencing consumer choice. *Journal of Consumer Research 2* (March), 302–319. See also Russo, J.E. (1988). Information processing from the consumer's perspective. In E. Scott Maynes (Ed.), *The frontiers of research in the consumer interest*. Columbia, MO: American Council on Consumer Interests

[5] Redish, Janice C. (1992). Understanding readers. In C.N. Barnum and S. Carliner (Eds.). *Techniques for technical communicators*. New York: MacMillan. See also Flower, L, Hayes, J.S. and Swarts, H. (1983). Revising functional documents: the scenario principle. In Paul V. Anderson (Ed.), *New essays in technical and scientific communication: research, theory, practice.* Fanningdale, NY: Baywood.

[6] Adlin, T, and Pruitt, J. (2010). *The essential persona lifecycle. Your guide to building and using personas.* Burlington, MA: Morgan Kaufmann

[7] Redish, Janice C. (1989). Reading to learn to do. *IEEE Transactions on Professional Communication, 32* (4): 289–293.

[8] Song, H., and Schwarz. N. (2008). Processing fluency affects effort prediction and motivation. *Psychological* Science, 19, 986–988.

[9] Kimble, Joseph. (2006). *Lifting the fog of legalese.* Durham, NC: Carolina Academic Press.

with a concept, such as the Health Insurance Marketplace, they need to have basic information introduced before they can navigate and make sense of additional details.[10]

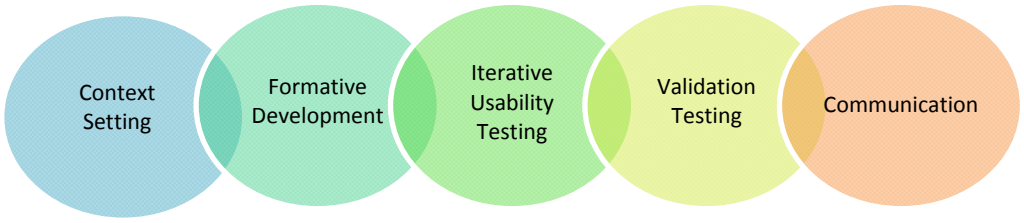
- **Readers read to do.** Readers are often active readers. They read to answer questions, but also to figure out what to "do" with the information they are reading. Explicit instructions and the numbering of each section to create steps can help readers move to action.[11]

As a further design consideration, the brochure needed to be "customized" for each individual state, so a consumer could act on state specific information in the brochure.

User-Centered Design and Testing Process

We developed the brochure through a user-centered design process that has five phases—each of which serves to generate and confirm ideas being developed (Exhibit 1). This process is designed to elicit and test ideas about optimal design that meet the goals of the study.

EXHIBIT 1. USER-CENTERED DESIGN PROCESS



For this study, we focused on Context Setting, Formative Development and Iterative Usability Testing. For context setting, we used the literature review developed by Consumers Union[12] and interviewed several key informants who help consumers enroll in private health coverage or who are tax preparers.[13] For the formative development, we conducted two focus groups in Towson, Maryland to explore reactions to initial designs of the draft brochures and reactions to the concept of an advance Premium Tax Credit. For the iterative usability testing, we conducted eight one-on-one cognitive interviews in each of two locations:

[10] Kitchin R.M. (1994). Cognitive maps: What are they and why study them? *Journal of Environmental Psychology 14*(1), 1–19.

[11] Redish, J.C. (1989). Reading to learn to do. *IEEE Transactions on Professional Communication, 32*(4), 289–293.

[12] Consumers Union conducted a literature review and contacted some financial literacy experts to understand the current state of knowledge with respect to consumer understanding of tax concepts and best practices in consumer facing tax "explainers." Please contact Consumers Union for a copy of a memo outlining the results of this scan.

[13] Three of the experts are independent accountants and tax preparers. The three health enrollment counselors hold various positions at Health Care for All (Massachusetts).

Oklahoma City, Oklahoma and Salt Lake City, Utah (Exhibit 2). One-on-one testing typically involves fewer participants than a traditional focus group approach, but the results are more nuanced and useful for revising the tax credit materials. According to Virzi, 80% of usability problems are uncovered with five participants and 90% with ten participants.[14]

The testing was designed to elicit problems in design and understanding and to allow us to fine tune concepts, wording and presentation. (See ***Appendix A*** for more information on the testing.)

In addition, at each site, stakeholders from the local health insurance community were invited to observe testing and to discuss their reactions to the three tested products. These stakeholders included staff from the state's Marketplace, staff from the state's Department of Insurance (DOI), consumer advocates, IRS representatives and an insurance broker.

80% of usability problems are uncovered with five participants and 90% with ten participants.

EXHIBIT 2. TESTING SITES

LOCATION	METHOD	MARKETPLACE TYPE	OBSERVERS
Towson, MD	2 focus groups	State-based	DOI, Marketplace, IRS, Advocates
Oklahoma City, OK	8 cognitive interviews	Federal-based	DOI, Broker, IRS, Advocates
Salt Lake City, UT	8 cognitive interviews	Federal-based	Marketplace, Advocates

[14] Virzi, R. (1992). Refining the test phase of usability evaluation: How many subjects is enough? *Human Factors 34*, 457–486.

Ten Critical Tax Credit Facts for Consumers

As we've indicated earlier, the Premium Tax Credit will help consumers pay for their health insurance, but it also carries the potential for financial liability. The brochure was design to convey ten important ideas to ensure that consumers could understand sufficiently to avoid harm.

The brochure was designed to convey ten important ideas.

Ten Critical Tax Credit Facts for Consumers

1. This is a tax credit program.
2. It will help you afford health insurance.
3. To participate, you must meet certain requirements. However, both lower and middle-income families can qualify.
4. You can use your tax credit only with insurance purchased from your state's new Health Insurance Marketplace.
5. You can take the tax credit in one of two ways with different benefits:
    - In advance, the tax credit lowers your monthly payments.
    - If not taken in advance, the tax credit lowers the amount of taxes owed or increases your refund at the end of the year.
6. Tax credit does not begin until 2014, but you can apply starting in October 2013.
7. If your income or family size changes, the amount of the final tax credit may change.
8. To ensure that any advance tax credit amounts are correct, you must immediately report income and family size changes to the Marketplace.
9. If you take the tax credit in advance and do not report changes, you may have to pay back overpayments.
10. You can get more information by contacting your state's Health Insurance Marketplace.

Participant Demographics

Participants were literate English speakers recruited because they appeared to be eligible for the new tax credits. They were non-elderly adults with family incomes of 100% to 400% of the federal poverty level (FPL) (Exhibit 3). Most participants did not have access to employer coverage and made health insurance decisions for their household. They were recruited to be evenly divided across:

- currently insured and uninsured,
- younger/older (young adults through 65)

We aimed for a diversity of gender, family size, race, ethnicity and education, but did not specifically recruit by these characteristics. (See ***Appendix B*** for detailed demographics.)

We did not recruit for attitudes toward the ACA nor did we mention the phrase in recruiting or the interview. However, many participants quickly surmised that the study was related to it. They tended to refer to it as "Obamacare" and typically knew few details of the law. That said, participants had a broad variety of attitudes with some warmly embracing the ideas in the ACA to some simply accepting its inevitability to some actively showing hostility to the new regulation. In many, but not all cases, participants became more positive about the ACA as they discovered the details of the breadth of its income inclusion and the depth of their potential cost savings.

EXHIBIT 3: INCOME LEVELS CORRESPONDING TO 400% OF FPL (FROM BROCHURE)

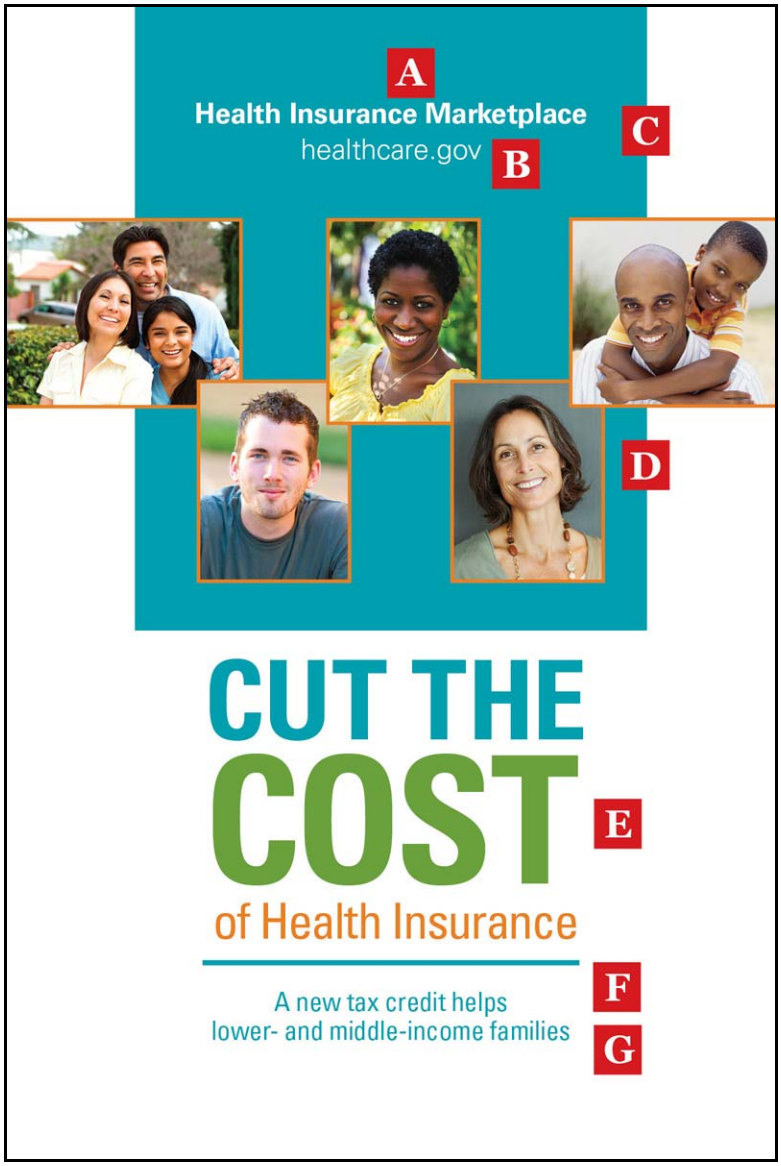
FAMILY SIZE	YEARLY INCOME
1	$45,960
2	$62,040
3	$78,120
4	$94,200
5	$110,280
6	$126,360

Chapter 2. The Final Brochure

The final brochure evolved over the two rounds of cognitive testing in Oklahoma City, Oklahoma and Salt Lake City, Utah. On the next pages, we present the final design of the brochure and identify the key elements of each section. The content and design elements help consumers more easily comprehend the information and the ten Critical Tax Credit Facts for Consumers.

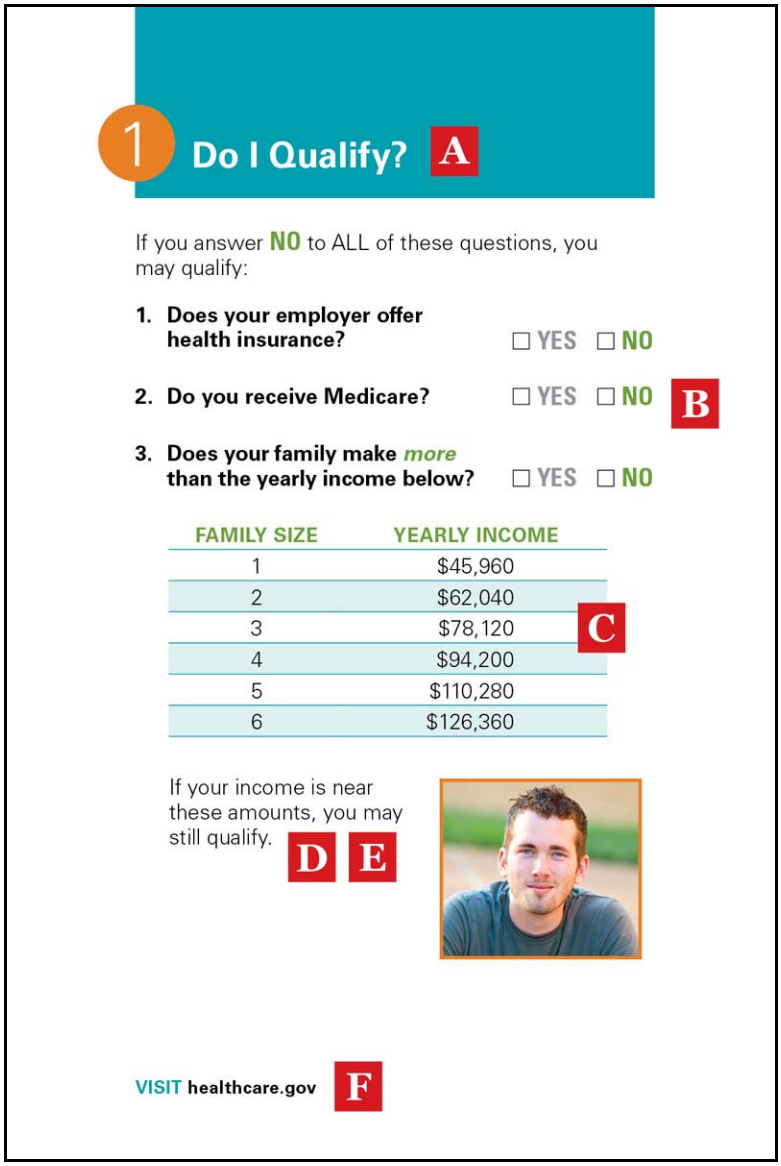
- **The Cover** provides the hook—verbally and graphically, encouraging consumers to pick up the brochure and begin to read.
- **Section 1. Do I Qualify?** provides a simple quiz of three questions.
- **Section 2. How Does the New Tax Credit Work?** provides a brief explanation of the Health Insurance Marketplace and the tax credit.
- **Section 3. Two Ways to Take the Tax Credit—You Decide!** is the heart of the brochure. It compares the two options for the tax credit: "Take It Now" and "Take It Later." This section also shows a photo of Jane, as an example, and shows how the two options differ for her.
- **Section 4.Taking Your Credit Now? Get the Right Tax Credit** explains the cautions and actions needed with the "Take It Now" option. The section also includes the story of Patrick and Claudia who forget to report a change of income and now must repay $2,000.
- **Section 5. How Do I Get Started?** provides basic contact information for the Marketplace and others and indicates who has distributed the booklet.

Cover Page



A	Places marketplace name in prominent position
B	Includes url here because .gov suffix was trusted
C	Uses position to show website address refers to marketplace
D	Creates interest with photos of diverse, happy faces
E	Emphasizes cutting health insurance costs
F	Includes reference to tax credit
G	Reinforces middle-income eligibility

Section 1. Do I Qualify?



1 Do I Qualify? A

If you answer NO to ALL of these questions, you may qualify:

1. Does your employer offer health insurance? ☐ YES ☐ NO
2. Do you receive Medicare? ☐ YES ☐ NO B
3. Does your family make *more* than the yearly income below? ☐ YES ☐ NO

FAMILY SIZE	YEARLY INCOME
1	$45,960
2	$62,040
3	$78,120
4	$94,200
5	$110,280
6	$126,360

C

If your income is near these amounts, you may still qualify. D E

VISIT healthcare.gov F

A	Answers first question consumers have
B	Uses simple checklist with correct answers emphasized graphically
C	Includes chart that shows income and family size eligibility
D	Indicates that income amounts are approximate
E	Indicates that families may still qualify if income is a little higher
F	Provides website address on each page

Section 2. How Does the New Tax Credit Work?

2 How Does the New Tax Credit Work?

What is this tax credit? A
The Health Premium Tax Credit reduces the total amount of tax you owe the IRS. If you don't owe, you can get a bigger refund. You get the tax credit to help cut the cost of your health insurance. B

Can I use my tax credit for any health plan? C
NO. You MUST buy your health insurance from:

Health Insurance Marketplace
1-800-xxx-xxxx
Healthcare.gov

This new marketplace offers a wide variety of health plans with good benefits. All plans cover prescriptions, hospital stays, doctor visits and more. If you buy different coverage, you won't get the tax credit help. D

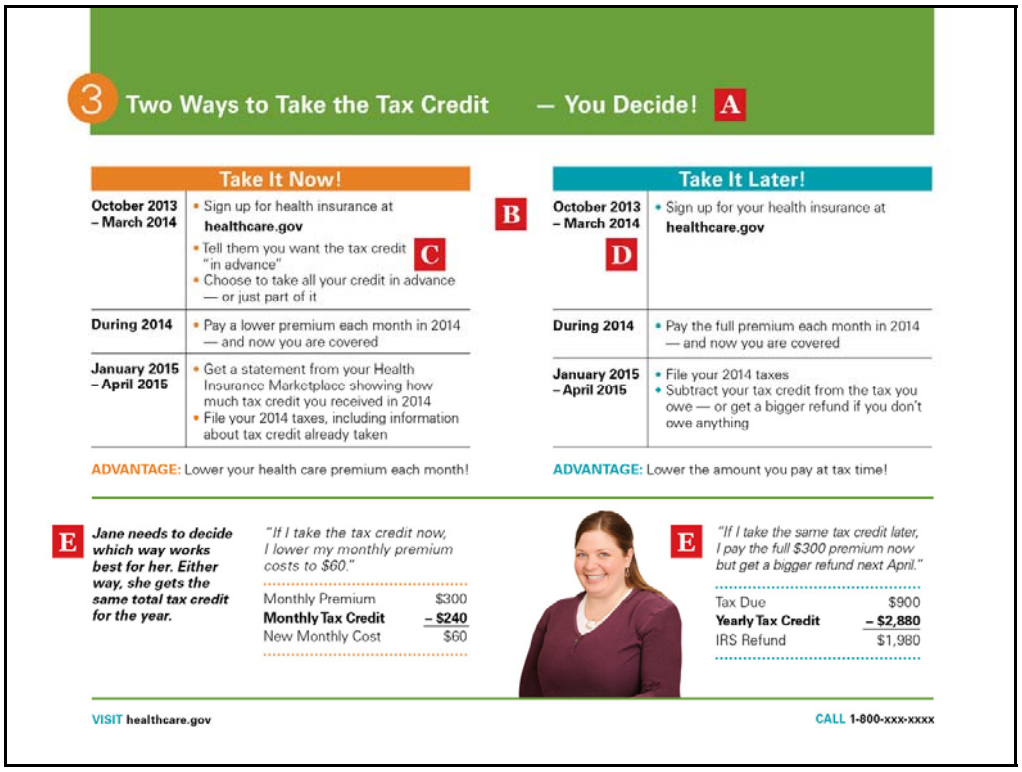
How much help will I get?
The amount depends on your family income and your family size. Lower income families get the most help.

When does it start? E
The tax credit begins with insurance that starts January 1, 2014 — or later.

CALL 1-800-xxx-xxxx F

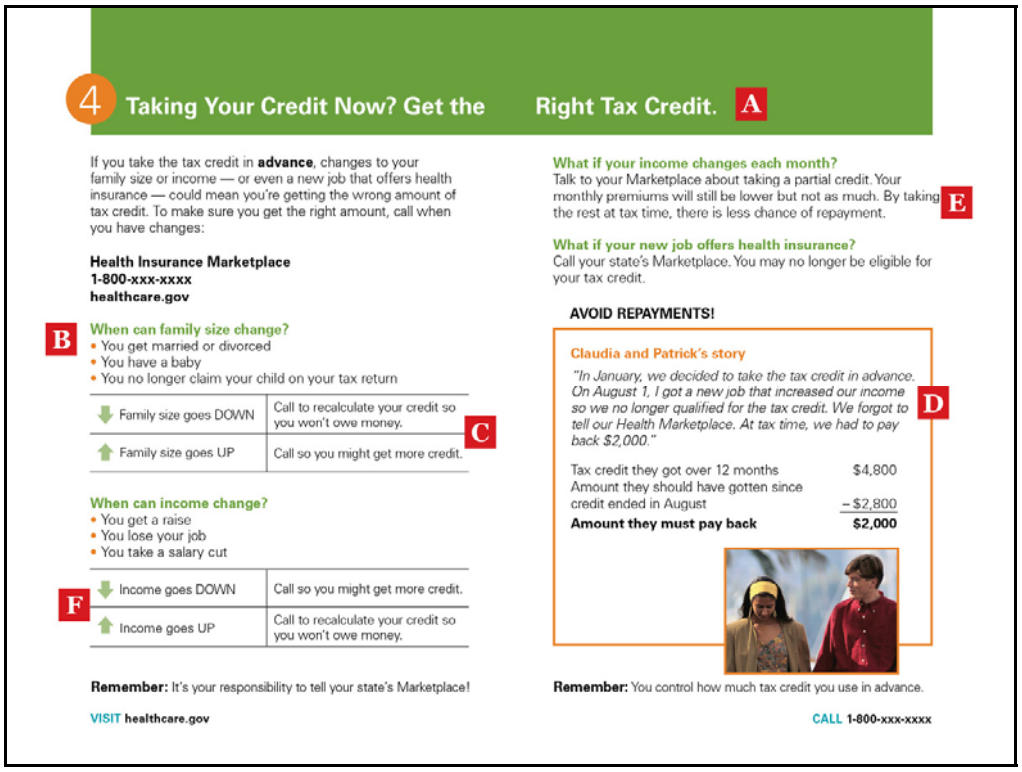
A	Names the tax credit program
B	Gives overview of the benefit of tax credit
C	States that health plan must be bought from Health Insurance Marketplace
D	Stresses that health plans are available with good benefits
E	Gives start date
F	Provides phone number on each page

Section 3. Two Ways to Take the Credit—You Decide!



A	Emphasizes there's a choice that consumer must make
B	Uses a table with strong parallel structure to compare the two options
C	Shows that partial tax credit advance is possible
D	Gives basic timeline and activities
E	Uses a personal story to provide an example and to emphasize the choice she has

Section 4. Taking Your Credit Now? Get the Right Tax Credit.



4 Taking Your Credit Now? Get the Right Tax Credit. A

If you take the tax credit in **advance**, changes to your family size or income — or even a new job that offers health insurance — could mean you're getting the wrong amount of tax credit. To make sure you get the right amount, call when you have changes:

Health Insurance Marketplace
1-800-xxx-xxxx
healthcare.gov

B
When can family size change?
- You get married or divorced
- You have a baby
- You no longer claim your child on your tax return

Family size goes DOWN	Call to recalculate your credit so you won't owe money.
Family size goes UP	Call so you might get more credit.

C

When can income change?
- You get a raise
- You lose your job
- You take a salary cut

F

Income goes DOWN	Call so you might get more credit.
Income goes UP	Call to recalculate your credit so you won't owe money.

Remember: It's your responsibility to tell your state's Marketplace!

VISIT **healthcare.gov**

What if your income changes each month?
Talk to your Marketplace about taking a partial credit. Your monthly premiums will still be lower but not as much. By taking the rest at tax time, there is less chance of repayment. E

What if your new job offers health insurance?
Call your state's Marketplace. You may no longer be eligible for your tax credit.

AVOID REPAYMENTS!

Claudia and Patrick's story D

"In January, we decided to take the tax credit in advance. On August 1, I got a new job that increased our income so we no longer qualified for the tax credit. We forgot to tell our Health Marketplace. At tax time, we had to pay back $2,000."

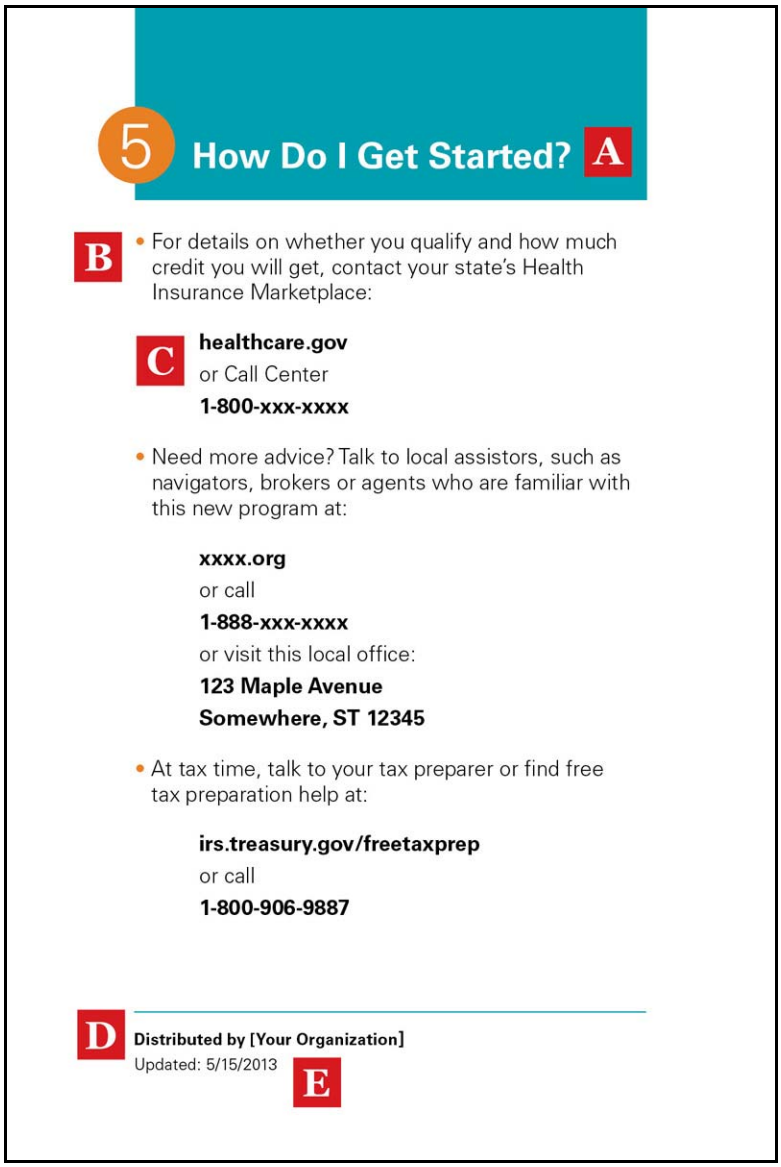
Tax credit they got over 12 months	$4,800
Amount they should have gotten since credit ended in August	−$2,800
Amount they must pay back	**$2,000**

Remember: You control how much tax credit you use in advance.

CALL **1-800-xxx-xxxx**

A	Emphasizes extra considerations if tax credit taken in advance
B	Links income or family size change to action needed
C	Shows why one should call
D	Uses a personal story to show the consequences of not calling
E	Provides information about what to do if monthly income fluctuates
F	Uses graphics to emphasize key information

Section 5. How Do I Get Started?



5 How Do I Get Started? A

B
- For details on whether you qualify and how much credit you will get, contact your state's Health Insurance Marketplace:

C **healthcare.gov**
or Call Center
1-800-xxx-xxxx

- Need more advice? Talk to local assistors, such as navigators, brokers or agents who are familiar with this new program at:

xxxx.org
or call
1-888-xxx-xxxx
or visit this local office:
123 Maple Avenue
Somewhere, ST 12345

- At tax time, talk to your tax preparer or find free tax preparation help at:

irs.treasury.gov/freetaxprep
or call
1-800-906-9887

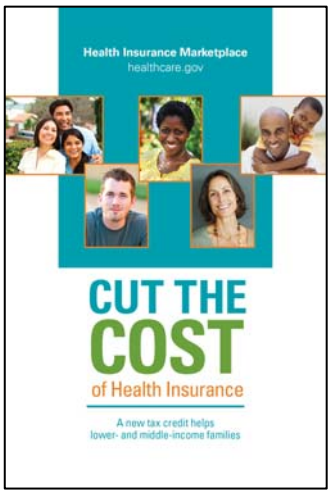
D **Distributed by [Your Organization]**
Updated: 5/15/2013 E

A	Provides a method for consumers to take action on the material
B	Provides three basic resources for contact information
C	Gives emphatic position to the Marketplace contact information—both website and phone number
D	Identifies who is distributing the information
E	Helps consumers assess currency of information

Chapter 3. Detailed Findings

The development of the brochure and supplemental products occurred over several rounds of consumer testing. The detailed findings below describe how we satisfied participants' immediate questions, as well as the steps we took to make the information usable, once they were willing to read further.

The Cover



As we developed the brochure, we found quickly that participants wanted some up front answers to three basic questions before they were willing to invest the time in reading the brochure. These were:

- Does this information apply to my specific family situation?
- Who is supplying this information? Is it a source I trust?
- What is the "thing" being described? (In this case, a tax credit that lowers the cost of health coverage.)

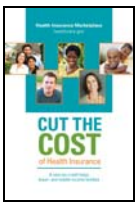
If participants could decide that the information was reliable and relevant to their personal situation, they were more willing to invest the time to read the brochure. They also needed to have some anchoring information about the program itself, in order to make sense of details inside the brochure.

Participants wanted the cover to create interest and to provide key information.

Our initial goal was to determine what messages and cover design would motivate participants to pick up the brochure and learn about the tax credit. We experimented with three cover messages and designs:

Now You're Covered; Claim a tax credit to lower your health insurance cost. This graphic presentation included the name of the Health Insurance Marketplace.

Get a Break! A New Way to Lower Your Health Insurance Costs and an additional sentence: "Many people can get a break with the cost of health insurance. See if you qualify." This graphic presentation also included the name of the Health Insurance Marketplace.



A New Way to Cut the Cost of Health Insurance. This presentation used five photographs of people of different ages, family size and ethnicity. It included the name of the Health Insurance Marketplace.

Nearly all participants preferred the message of "Cut the Cost" because cost was important to them.

Many participants were concerned about the costs of health care and responded well to the emphasis on cost savings, which was an important consideration for them.

> "Cut the costs, everyone can relate to cutting costs and saving money." *Oklahoma 006*
>
> "Cost is the first thing I saw and then cut the cost…Cut the cost got me." *Oklahoma 007*
>
> "The cut the costs is an attention grabber. It makes me want to pick it up and look at it, and see what they are talking about. Everyone wants to save money, especially the way the economy is doing nowadays." *Utah 001*
>
> "Also, it talks about cost right away, cutting costs. And I'm not working right now. Money is a problem, so that catches my eye." *Utah 007*

Some participants wanted the "tax credit" mentioned.

Some participants also liked the mention of tax credit specifically on the cover. While cutting health insurance costs is compelling, for some it was too vague about how the cost was being cut unless a reference to the tax credit was included.

> "Tax credit help—that has got my interest—that it's a tax credit…It's a lot better than a deduction." *Oklahoma 001*
>
> "I think two things should be emphasized, the tax credit and cutting the cost, I think there is some legitimacy to showing cost saving is due to some government program. I think that in itself makes it somewhat reliable…But tax credit is emphasized—I think it would be somewhat appealing." *Utah 005*

Participants viewed government as a trusted source and wanted a reference to it on the cover.

Many participants felt that a reference to the government gave the brochure more credibility. Some were concerned that the brochure was being produced by a private company and would be a "sales pitch" as opposed to credible information. In all our testing sites, most participants felt the government would be the most credible source. In Maryland, where the name of the Marketplace is "Maryland Health Connection," having the state's name featured prominently in the

brochure helped anchor participants that this was a government program and the information could be trusted. In a few instances, participants wanted the source to be the state government and, for some, the federal government was preferred over the state government. Even though many participants felt it would be difficult to deal with a federal or state agency, they also felt that information provided from that source would be reliable and unbiased.

Reference to the government gave the brochure more credibility.

> "Because we can trust the government more than private entities, especially where health care is concerned. Because private entities are more likely for profit, they are trying to get me to buy whatever they're doing. I don't think the government is doing that." *Oklahoma 007*

> "It [the government] is a trusted source. It seems like any time you open an email, there are like a hundred different insurance companies from out there, that you don't really know who they are or where they are. So at least thinking that it says '.gov', it adds credibility." *Utah 004*

> "I guess it matters to the extent that if it's something coming from the government you sort of think of it as neutral whereas if it's coming from a private company that's giving you this, they might be biasing it towards 'come work through our company to get this stuff.' That you're getting [it] from the government or something—that's the place where I would see that it might matter." *Utah 003*

> "For the simple fact that if it is from the state, I would be more interested in it than if it is from a private place because the private places, they can up and go at any time." *Oklahoma 003*

Participants responded well to the pictures of smiling people on the cover.

Nearly all participants liked the pictures of smiling people and the diversity that they represented. Most saw it as a way of showing that many people would be included and that regular people were the target for the brochure. In Salt Lake City, for one version, we substituted the photos for ones with medical personnel and patients, but participants still preferred the pictures of smiling people.

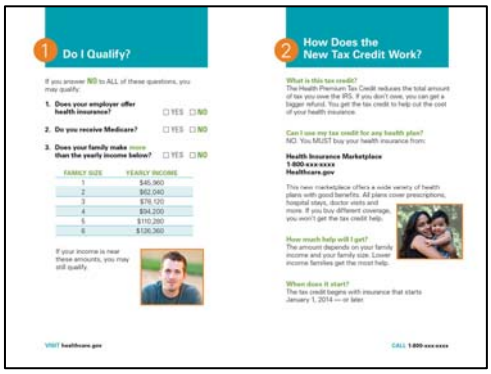
> "Pictures in general are a little more engaging than just this [words]." *Oklahoma 006*

> "…it is more eye appealing. It has people, families and more colors." *Oklahoma 005*

> "The pictures really stand out with me because I look at a picture before I pick it up to read it. My seeing there is a family and then cut the cost with that being so big and bold, that would be the eye-opener for me." *Oklahoma 003*

> "I did like the pictures on this one better now. This is real people, and this is just doctors." *Utah 004*

Sections 1 and 2



After picking up the brochure, participants wanted to know if they should read on. They wanted to see if they were eligible for the program, but they also needed some information about the program so they could anchor the information on eligibility.

Participants wanted to know immediately if they were eligible and could easily answer the three eligibility questions.

To assess eligibility, participants had to answer three questions; (1) did their employer offer insurance; (2) were they on Medicare; and (3) did their income for family size fall above the amounts listed in a table. If they answered "no" to each, they were prompted to move on to learn more. The three questions were easy for participants to answer, and most had little difficulty deciding if they might be eligible. A few commented on the unexpected approach of using a "no" answer for the income eligibility question, but no consumers had difficulty using the questions to decide if they were eligible.

> "[I'm looking at] the first page, the first item being "do I qualify?" To me it comes across—that is nice in that I want to know immediately if it is something for me, so that works for me." *Utah 005*

> "It is nice to be able to see right away if I qualify…Also the 'no's' are good and they are green, that is cool. That makes sense." *Utah 007*

> "That's interesting—answering 'no' rather than 'yes.' That's different than your average questionnaire…That might be confusing—you're so used to answering yes. In Oklahoma we even passed a law for our ballots that if there is a proposal for a state question and you want it to pass, it has to be worded in such a way that in order for it to pass, the answer is 'yes.'" *Oklahoma 001*

Participants often confused Medicare and Medicaid.

The new tax credit is not available to people with access to other coverage, such as Medicare, Medicaid or employer coverage. As previous research has also shown[15], many of our participants confused Medicaid and Medicare. The two programs sound very similar.

[15] SHADAC, *Issue Brief 9*, January 2004, "Do national surveys overestimate the number of uninsured? Findings from the Medicaid undercount experiment in Minnesota" http://www.shadac.org/files/shadac/publications/IssueBrief9.pdf

"It's a program that the government has in place to help people with healthcare. People that qualify—old people and people that are disabled. I think that's it." *Oklahoma 007*

"Medicare is, I pay taxes and children and the elderly get medical through the taxes that me [sic] and other taxpayers pay at little or no cost to them. That is my idea of it." *Oklahoma 005*

"It's a governmental program that's supposed to be set out to help provide health costs for people that are in certain levels of income…" *Utah 002*

"It is a program from the government. That is all I know." *Utah 004*

"It is a federally run health insurance for children. " *Utah 005*

Even though people eligible for Medicaid are not eligible for the tax credit, we did not include this additional question for several reasons. Because people are confused by Medicaid and Medicare, in some ways, a single question sufficed for both programs. The normal technique for clarifying these two programs is to add explanatory material or the local name of the Medicaid program, but we didn't have room for this. Second, we wanted to limit the number of questions in this section, so that completing the eligibility worksheet was simple to do. Third, if Medicaid-eligible persons misunderstood their eligibility for the tax credit, the worst outcome was that they would call the Health Insurance Marketplace for more information and then learn about their Medicaid option.

Most would call even if their income was a little higher.

We asked participants their views on the upper-income limit shown in Section 1. Many assumed that income would be counted in ways that had a bit of flexibility. When asked how much over the listed amounts they would think it still possible to qualify, most gave a number within 10% over what was listed. This was an important outcome because there are many reasons why a family with an income a bit over the limits might still qualify.[16] In general, participants said they would call or would check the website if their income was near the listed amount. One participant wanted to call to see if he could negotiate to get his income within the limits. For Salt Lake City, one version of the brochure included the statement "If your income is near these amounts, you may still qualify." It resolved the issue for these participants.

Participants said they would call even if their income was a little higher than the listed amount.

"I would probably still call to see if I qualify." *Oklahoma 005*

"I would probably look [at website]." *Oklahoma 007*

"I guess I would try and call them and see what options I have available. If I could work a deal where I could pay more to supplement that gap...Is there

[16] Income for the purpose of tax credits is defined as modified adjusted gross incomes (MAGI). This is similar to adjusted gross income (AGI) on one's tax return except that it includes certain foreign earned income and tax-exempt interest. Adjusted gross income can be lower than gross income because it excludes tax-deferred income, such as qualified contributions to retirement accounts.

some amount that I can pay more? Something that can fit within that yearly income range..." *Oklahoma 002*

"At that point, I would probably go to the website and just see what the ramifications [of having a higher income] would be…I've got a family of five, so if I made another $10,000 above that—a $120,000 a year, I probably wouldn't do anything at all." *Oklahoma 001*

Participants were pleased that the tax credit program covered middle-income levels.

Many participants had a pre-conceived notion that programs like this are not for middle-income families. It was important for the brochure and other consumer communications to counter-act this assumption. To do this, the cover specifically mentioned middle-income families. Further, the maximum income levels in the qualification table in Section 1 were visually very prominent.

Participants were surprised and pleased that these levels were higher than they expected. One participant even commented that it was good that the program was aimed at middle-income families.

"…the income is fairly high, quite honestly, for five or more people…I think the medium income in the United States is around $54,000–$55,000. So for people that is pretty…that is a fairly substantial income, I would say actually higher income as well. That is fairly substantial." *Oklahoma 002*

I think it will help lower middle-class and middle-class the most. The lower class, from what I am understanding, pretty much get free health care—like the disabled, people on SSI, disability, pretty much get free health care as it is, so this is for people who have to pay for it and it kind of makes it more cost-efficient for them." *Oklahoma 005*

"Then it gives income ranges. Once it's at $45,000, $62,000, $78,000, $94,000…it seems pretty big." *Utah 002*

Participants wanted more information about the Health Insurance Marketplace.

Because no major public information campaign had begun to educate consumers about the Health Insurance Marketplace, consumers were unfamiliar with the concept and the name "Health Insurance Marketplace." They were unclear if the Health Insurance Marketplace was a government or private entity. At least one person thought it might be a cooperative of private companies. As we had seen earlier, this ambiguity created a slight element of distrust.

Participants were unclear if the Health Insurance Marketplace was a government or private entity.

"It doesn't seem like it has a clear-cut…is it a company? It seems very ambiguous." *Oklahoma 002*

"It wasn't clear whether this is through the federal government, like I said, or a state medium, or if this was a private company." *Utah 001*

"'Produced by Health Insurance Marketplace,' I mean that should always be added, but, I mean, at the same time, I hate to say it, but it doesn't really make it clear if it's a lobbying group, if it's a private corporation, et cetera." *Utah 002*

"It mentions a name that I am not familiar with…For me, I would like a little more information on what it is, maybe how it works, not necessarily how it works, but why it was setup, why it is in place." *Utah 005*

"I think that it actually possibly could be, well say this is Aetna, the company has got some marketplace, so then you are actually going to log on, then you are going to find someone who is going to best suit your needs…It looks to me as if it is that group of things that they have come together and they have put this out." *Utah 006*

Without a clear idea of what the Marketplace was, they were initially often confused about the relationship between the tax credit, the marketplace and health insurance plans. We needed to give them enough information about the marketplace that they felt sufficiently anchored and would continue to read. To address this, we added a simple explanation that the Health Insurance Marketplace offered several health plans with good benefits. Once they understood a rudimentary concept of the Health Insurance Marketplace, they more easily could place the information about the tax credit in context. With more consumer outreach on Marketplaces, this confusion may dissipate.

Participants wanted more information about plans and benefits.
Related to the issue of ambiguity about the Health Insurance Marketplace, many participants were concerned that the tax credit might be limited to plans with poor coverage, and so were reluctant to decide if they were interested without knowing more about the plan specifics. Oklahoma participants particularly thought that the Marketplaces would have limited plans with limited benefits. For Utah, we added a statement about "wide variety of plans" with "good benefits" and participants were more satisfied, although some continued to look for details about specific costs, benefits and coverage.

Participants were concerned that the tax credit might be limited to plans with poor coverage.

"It means, you know, automatically, I'm going to be limited because only qualifying plans are going to be offered. I may not like that. I already don't like it and I'm in the free market for it [health plans]…I would be concerned I would have less choice, less flexibility…" *Oklahoma 001*

"[I want to know] stuff that's not covered here [in the brochure]–what kind of coverage it is, what the copays are, how much it would actually cost because I know this is an example back here…if my doctors are going to be on the plan." *Oklahoma 007*

"[I'm looking for] How much plans are, what the premiums are, there is no indication of what it would be…." *Utah 005*

"I would call. I would call the number [to find out] what it covered. First of all, I would say, of course, how much? What's the premium? What does it cover? What's excluded? What's included?" *Utah 008*

When asked how many plans they thought would be in the marketplace, participants told us the brochure seemed to indicate several plans.

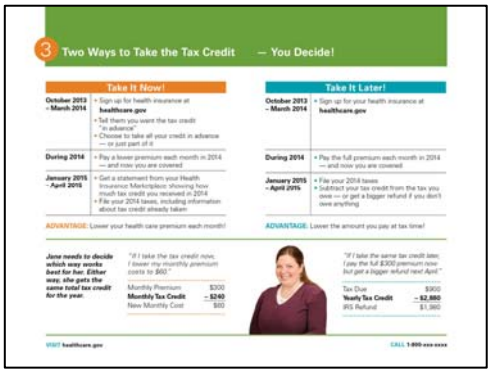
"It says it has a wide variety of health plans…But something I've always noted about health insurance. They did say they have a whole bunch of different plans. But there's usually a range of three, total." *Utah 002*

"[I'd expect] four or five probably." *Oklahoma 007*

"I would say a medium amount. I don't think it would be a few. I think they would give you quite a few options." *Utah 006*

"How many plans? I would say probably like 20 or more. Twenty seems logical to me." *Utah 004*

Section 3



Section 3 of the brochure provides a significant amount of information, including information that consumers are unlikely to have encountered before, such as the advanceable nature of the tax credit. We used simple terms to illustrate the choice a consumer would have to make: "Take It Now" or "Take It Later." The phrase "You Decide" in the header alerted them that there's something they must do. We also used a table-style timeline to illustrate, in a parallel way, the differences and similarities between activities associated with the two options. A personal story made the abstract concepts concrete.

Participants readily understood the timeline.

The timeline of selecting and using the tax credit is long and crosses three years: 2013 for enrollment, 2014 for coverage and 2015 for reconciling the tax credit on 2014 tax returns. Because of the multiple time periods, we expected that participants would have difficulty with the sequencing of events.

The table format for the timeline allowed participants to readily see the parallel activities for each option and highlighted the differences between the two options. The simple headings with dates further allowed consumers to skim and still identify the key points for each option. With one exception, nearly all participants could identify the time period for each key activity. Using a parallel structure made the important differences clearer. Nearly all participants could articulate the difference between the two options for taking the tax credit. The

A timeline showed the activities and highlighted the differences between the two options: Take It Now or Take It Later.

timeline also draws out the advantage of each option. Most could articulate the advantages, and some could infer the disadvantages of the two options.

For the most part, participants knew when they could apply for health insurance.

In general, participants understood that the period of enrollment for health insurance began in October 2013. Some understood that the enrollment period would continue until March 2014. They also understood that the tax credit would apply to insurance in 2014.

> "October of this year." *Oklahoma 001*
>
> "You could do it after October of this year." *Oklahoma 007*
>
> "Sign up starting October 2013 to March 2014." *Utah 003*
>
> "I would need to be signing up by the end of the year between October to March." *Utah 006*

Participants initially had some difficulty knowing when the insurance coverage began.

In early versions of the brochure, participants had some difficulty identifying the start of their insurance coverage—some thinking it would begin as soon as they applied. Participants could not infer the start date from the information in Section 3 which said that "During 2014" they would be paying a premium. In the final version of the brochure, we added language to make this more explicit.

> "Should be January I would think." *Oklahoma 001*
>
> "I don't know." *Oklahoma 007*
>
> "I don't think that it says that anywhere." *Utah 003*
>
> "October 2014. No, it just says 'during' so it doesn't actually have a date listed. Am I missing something?" *Utah 006*

Most participants knew which year's tax return was affected.

Most participants understood that the tax credit would affect their 2014 tax return which would be filed in 2015. They also understood that if they chose the "Take It Now" option, their tax burden would remain the same, since they had already received the credit in advance.

> "It [health insurance] would begin I guess it would start in 2014…You get the credit starting in 2014, but it doesn't show up on your taxes until you file in 2015." *Utah 004*

A single story showing both options worked better than two stories.

Despite the clarity of the timeline of activities, participants appreciated the personal story to make the information concrete. It gave them confidence that they were understanding the information correctly and that it applied to people

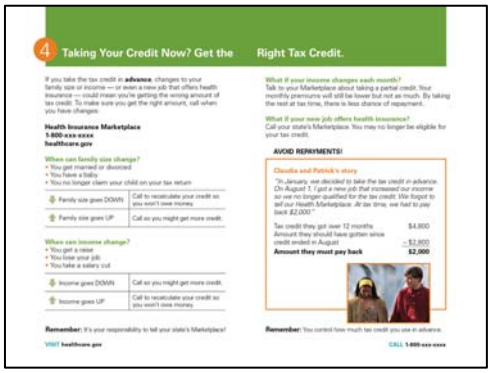
like themselves. The photo and short story seemed easier to read and it showed how the abstract tax credit would work in real life.

> "…it gives you more of a humane connection other than here it is, black and white, this is what it is." *Oklahoma 005*

In earlier versions, the bottom of each page used a separate story (about 3 sentences) to illustrate how the tax credit affected two people: one took the tax credit now and one took the tax credit later. When we used this approach, it was difficult for some participants to contrast the two situations. Unable to see the differences, it was hard for these participants to judge which was a better option. In the final version, the story used one character to show how the two different options would affect that one person.

Section 4

An important goal for the brochure was to introduce the possibility of repayment if participants took the credit in advance. Many consumers may not have the savings needed to repay the IRS, if they get too much credit in advance. Because of the risk of an unexpected financial burden, we wanted to be sure that participants would read this section so we initially used the phrase "Avoid Penalties!" prominently displayed.



Early rounds of testing showed that a highly visible warning did ensure participants would explore the rather dense information of this section, but it also created a negative reaction to the advance tax credit. Not only was the word "penalty" too strong, it was also inaccurate. Switching to the more precise word "repayment" allowed participants to see the repayment not as a punishment, but as a simple consequence.

Participants understood why they should notify the Health Insurance Marketplace of changes in their income or family size.

Participants understood that changes in income and family size could increase or decrease the amount of their tax credit. Participants understood the need to call the Health Insurance Marketplace when these things changed. In addition, they understood that the consequence of an overpayment would require a repayment at tax time.

Although a few saw the reporting as burdensome, nearly all saw the reporting as simply a part of their own responsibility. While they wished the added burden of reporting to the Marketplace wasn't necessary, they felt it was a fair requirement, in keeping with getting a benefit like the tax credit.

Nearly all participants saw reporting income or family changes as simply a part of their own responsibility.

"So if any of this happens you probably won't owe money, but telling the health plan marketplace might mean a larger payment now. It doesn't hurt to call and find out. It's your responsibility to keep them informed." *Utah 008*

"…because you are getting the tax credit based off of certain things, like income, family size and things like that. And if those things change, what it [tax credit] is based off changes, and you are going to call….if you receive more, then you would definitely have to call them unless you wanted to pay more back at the end of the year." *Oklahoma 005*

"It's a consequence for your actions. So by not telling the insurance people that you got a raise, you have a consequence for your actions." *Oklahoma 007*

"It is your responsibility to tell the Health Insurance Marketplace…People just need to be reminded they need to be accountable for…Tell you, if I had another kid or this, that, or the other…and I pay too much or too little, I suffer. It's not you guys that suffer. It's me." *Utah 004*

Participants read the repayment story as appropriate and reinforcing their own sense of responsibility.

Most participants reacted neutrally to the story about Claudia and Patrick not informing the Marketplace and saw it as an appropriate consequence of not reporting changes as required. At the same time, the story served to reinforce the potentially expensive consequence of failing to report changes.

"You informed them, they took the money and were in possession of that credit, that money, and they have to pay it back…It is like you forgot, but you really need to be the adult and take responsibility that you are doing it. You need to see it through and if you default on your end, there is going to be a consequence." *Utah 001*

"Just really keeping you aware that if there are any changes in your life, you need to be contacting them...because that way you are aware that you are not going to get some crazy $2000 [repayment bill] or something at the end of the year. *Utah 006*

"…this is very important because a lot of people don't…you want someone to hold your hand and take care of you. You have to be responsible for yourself. You have to take the initiative and avoid penalties or whatever. Your life change [sic] and you have a baby, you have to take care of it yourself and let them know." *Oklahoma 002*

"It's not a penalty. It is just more making things whole. Making things square." *Utah 004*

We tried two approaches to Section 4.

To make the information in this section actionable, we described the types of changes that could cause a family to receive the wrong amount of tax credit in

advance (too much or too little). In our testing, we tried two approaches to listing these changes.

For the final brochure, we listed these changes by what happens to the family: "When can family size change?" or "When can income change?" We included a small table that showed what to do when either of these went up or down.

The alternate method, which also worked well, was to organize the changes in terms of what would give a consumer too much or too little credit (Exhibit 4).

EXHIBIT 4. ALTERNATE VERSION FOR SECTION 4

Changes that might leave you with TOO MUCH tax credit taken in advance:

- You get a big raise
- You get married, raising family income
- You can no longer claim your child on your tax return
- You get a new job that offers you health insurance
- Your income goes up and down each month and is hard to predict

Changes that might leave you with TOO LITTLE tax credit taken in advance:

- You have a baby
- You get divorced and family income goes down
- You get married but one spouse doesn't work

Participants usually strongly preferred one version or the other. However, we observed that participants who seemed more knowledgeable about taxes tended to prefer the Alternate Section 4. These same participants often selected the "Take It Later" option and were more comfortable with the more abstract concept of "tax credit." For many other participants, the tables were more concrete by referring to income and family size, not "tax credit." They were more explicit in stating the results of notifying the Marketplace, and they were slightly more graphic with the use of arrows. For these reasons, we did not use the Alternate Section 4 in the final version.

That said, Alternate Section 4 did work for many consumers. Based on testing results, this alternate approach could be useful in other tax credit communications.

The advantage of using a partial credit when income fluctuates was difficult to convey.

Another concept for consumers is that a partial credit is available. In this option, they take part of the advance tax credit to reduce their premium payments, but take the remaining portion at tax time. This combined option may be a good alternative for families with unpredictable incomes and few resources to repay any overpayments at tax time.

In the interviews, we asked a specific question about which option would be better with a fluctuating income. Participants overwhelmingly chose the "Take It Now" option as the best solution, primarily so that monthly expenses would be more affordable, but rarely mentioned the partial credit. Many in Oklahoma skimmed over the statement about partial credit in Section 3. To address this, our revisions created a separate section about partial credits in Section 4. After that change, more (but not all) participants commented that the partial credit was safer than taking all of the credit in advance.

> "I would see if there is any way to take a partial credit, not use the full credit that they allow, maybe just half of it and that way if it [your tax credit] does fluctuate you still have$1,440 put away towards it [any overpayment] and that way, if you don't qualify for the same amount, you didn't use it all." *Oklahoma 005*

> "And this is saying you can mix it, which is good to know. I think a lot of people will be open to that. It is kind of the best of both worlds, lowering your monthly cash outflow and not risking at the end of the year. So it is nice to see that this is an option." *Utah 005*

Section 5

Participants could correctly determine that they were likely to qualify and they told us they would act on the information. To help them act, the final page of the brochure included three sources for further help: the Health Insurance Marketplace information, in-person assistors (like a navigator or broker) and a tax preparer or the IRS website and phone number.


5 How Do I Get Started?

- For details on whether you qualify and how much credit you will get, contact your state's Health Insurance Marketplace:

  healthcare.gov
  or Call Center
  1-800-xxx-xxxx

- Need more advice? Talk to local assistors, such as navigators, brokers or agents who are familiar with this new program at:

  xxxx.org
  or call
  1-888-xxx-xxxx
  or visit this local office:
  123 Maple Avenue
  Somewhere, ST 12345

- At tax time, talk to your tax preparer or find free tax preparation help at:

  irs.treasury.gov/freetaxprep
  or call
  1-800-906-9887

Distributed by [Your Organization]
Updated: 5/15/2013

Participants said they would contact the Health Insurance Marketplace.

Of the options presented in Section 5, almost all said they would start with the Health Insurance Marketplace information. A few said they would call the Marketplace and more than half said they would visit its website. Reasons for the preference were varied, often reflecting a personal style. Some were simply more comfortable asking questions and getting answers through another person. Of those who chose the website, some wanted to avoid the wait times on a phone

call, and others found it more efficient to start with websites. These people were often confident in their ability to make use of the information they expected to find there. At least two participants suggested a "chat" option be provided on the website.

> "I would call. I would call the number." *Utah 008*
>
> "I'm disinclined to call any number where I have to push buttons to talk to a person, especially multiple buttons to talk to a person. If I'm going to send 10 minutes beeping through to something, I would rather (a) go on a website and (b) go on a website. I have to be on hold. It's the worst thing ever." *Oklahoma 007*
>
> "I would probably go to the website and just see what the ramifications would be. I probably wouldn't take the time to place a phone call and risk being on hold for 30 minutes, 45 minutes and that kind of things. Not to be on hold, but [to] commit myself to a 30 to 45 minute conversation." *Oklahoma 001*
>
> "Probably look online about it because I think looking online about it, I would get more information than I would from talking to some people. To me, if you are talking to customer service, they are probably reading what I can read myself." *Oklahoma 003*
>
> "…on the website, if I did have time, I would do a chat if they do that as well. That's easier too." *Utah 004*

Very few participants thought they would contact the other options. A few were simply unclear about the second option, and the IRS was poorly perceived as a source of information.

We identified the distributor of the brochure.

Reflecting participants' concerns about the source of the brochure, we increased credibility for the brochure by adding a line on the final page intended to designate who had paid to print the brochure they were reading. This was only modestly successful. Some participants did feel that the "distributed by" information was helpful, but many did not notice it. Nonetheless, we recommend keeping the reference in for those participants who are looking for such information.

Impact of Brochure

As participants worked through the entire brochure, they were able to integrate the information from individual sections into a more complete understanding of the key messages. This integration allowed nearly all participants to understand the basic differences between the two options, identify the advantages and disadvantages of both options, weigh which option would be a better choice for their personal situation and make a selection.

After reading through the brochure, most participants understood the key messages.

Most participants understood the purpose of the brochure—to inform them about a tax credit that could be taken in two ways.

> "To give people information about choices for their healthcare, so that if you don't have it from your employer, or if the government is not already paying for it, then this is a place to go to, to possibly get it cheaper than you may at other places, out in the free market. Or at least the government will give you a tax assistance when you file your income taxes. That's what it looks like to me." *Oklahoma 004*

> "To let people know that there is a tax credit that will go along with it [required health care]." *Oklahoma 008*

> "It is letting you know right away…that you are going to get a tax credit if you qualify so that you can afford to take better care of yourself and your family." *Utah 001*

> "The purpose seems to be that they're trying to let you know about what's out there in the way of tax credits that you could qualify for either taken two ways—either take it now and lower your premium or take it later and get a refund back at tax time." *Utah 003*

> "Options that are available to me. That if I go in, that I could lower what I am paying every month. Or, get my insurance and then have a nice refund at the end of the year." *Utah 006*

All eligible participants said they would take action.

Regardless of their preconceived notions about "Obamacare," nearly all participants who appeared eligible for the tax credit said they would take action. They felt it would help their families and they would call the Marketplace or go to the website.

> "..it [the brochure] does at least take me to the steps to go online and to further my knowledge of the program a little bit more. It gets me interested and makes me think—what am I missing out on, what am I getting here." *Utah 001*

> "I might call." *Utah 002*

> "Like I said, I would go probably to healthcare.gov and see more information." *Utah 003*

> "I would look at the website." *Oklahoma 007*

> "It gives me a little more thinking that there is something out there trying to help us out." *Oklahoma 008*

Nearly all participants who appeared eligible for the tax credit said they would take action.

All could articulate a decision about when they would take the credit

To test their comprehension, we asked participants which option (Now or Later) they would choose. Almost all participants were able to articulate how the advantages and disadvantages related to their particular situation.

About half of the participants chose the "Take It Now" option.
Over half of the participants selected the "Take It Now" option as a way to make the health premium costs more affordable. Participants were aware of the possible drawback of this option (repayment), but saw this as the most advantageous for their personal financial situation. Some participants saw this option as a way of coping with insufficient income—the reduced health premium payment would give them greater flexibility with monthly expenses.

> "I would probably take it now. It would seem like helping the monthly bills would be more advantageous than getting a refund." *Oklahoma 001*
>
> "I would probably take it now because it would be a lower premium, and I like lower premiums…It is basically like you take it now and that is $2,880 that you will receive less on your income taxes. If you take it later, that is $2,880 that you will receive more possibly…You receive less in their income taxes and if you take it later, you will receive more because you paid full price for it [health care premiums], so you get the full refund back." *Oklahoma 005*
>
> "…I would love to have the tax credit at the end of the year and have all that money at one time because it would be a tax savings, but just financially that [monthly premium] would be too much of a burden on someone to be able to pay that much." *Oklahoma 005*
>
> "Not knowing what the monthly health plan, what I'm actually going to have to pay out of pocket that just decreases my margin on what happens if my car breaks or my current favorite thing to have break is my central heat and air system. I had a little board that was replaced last month to the tune of $650." *Oklahoma 001*
>
> "Whatever I can get in my pocket now would be more important to me than what I could get on my refund." *Oklahoma 007*
>
> "Well, you would need the tax credit probably to afford the health insurance anyways." *Utah 002*

About half of the participants chose the "Take It Later" option.
About half of the participants preferred the "Take It Later" option for various reasons. For some, it was a matter of controlling their money—they wanted it as a way to force savings or to have a larger, lump sum refund. Some wanted to avoid the possibility of repayment. In response to our specific question about fluctuating income, only a few saw the "Take It Later" option as a way of dealing with that particular situation. At least one wanted to see how the initial year of the tax credit would work before risking the "Take It Now" option.

About half of the participants told us they would prefer the "Take it Now" option and half would "Take it Later."

"[I would be] probably taking it later. Because then you have a chance to have it [tax credit] assessed all at once rather than bringing it out. Some people would probably want to take it every month. I would rather do it in a lump." *Oklahoma 002*

"I would be inclined to take it later because my income fluctuates too much." *Oklahoma 003*

"Personally I would take it later because I prefer to have a good surprise [the refund] at the end of the year…from my understanding, if you do the yearly, month to month changes might not necessitate you having to contact the appropriate authorities every time something happens, but with the month to month something happens you need to let them know asap…" O*klahoma 006*

"I would be more inclined to take it later and see how everything pans out because really right now our government has not enacted any of the health care laws and we are not going to see a change or a difference until this year and this tax season, so I would see and go from there how these are rolling down the hills." *Utah 001*

Chapter 4. Findings on Supplemental Products

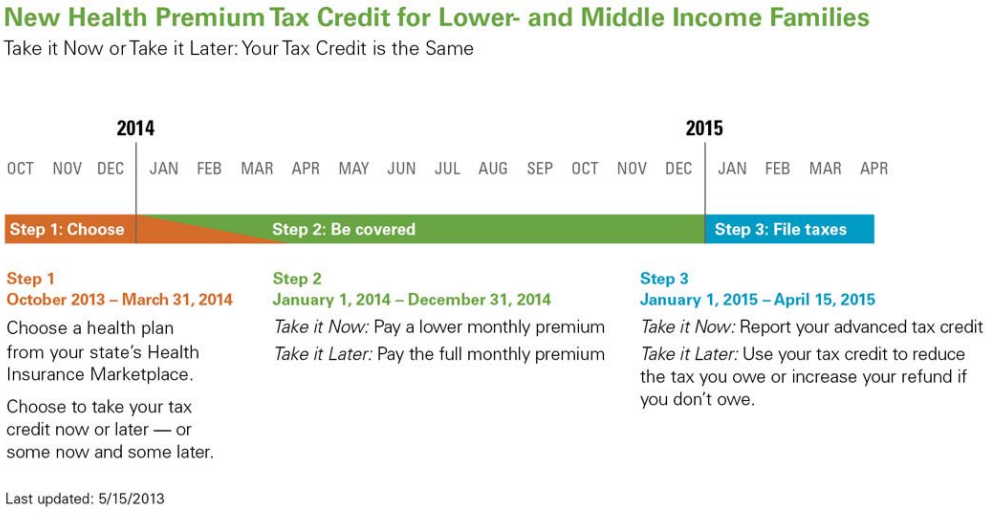
In addition to the brochure, we developed and tested an alternate timeline and a worksheet to be used by assistors. These products were tested with participants to determine if the products offered any additional clarity about the tax credit.

The Timeline

Most participants did well with the timeline included in Section 3 of the brochure. However, because that timeline was stacked with one date under another, we developed a timeline that used the traditional linear arrangement for time (Exhibit 5). A few participants preferred this option and no participant had difficulty understanding it.

The alternate timeline is not customizable, so it can be used by consumer assistors "as is." However, it is insufficient to explain the Premium Tax Credit on its own.

EXHIBIT 5. ALTERNATE TIMELINE



The Worksheet

We also developed a worksheet that assistors could use with an individual to show the basic calculation of his or her specific amount of the tax credit (Exhibit 6). In our study, the moderator assumed the role of the assistor to "walk" the participant through the worksheet, customized for a hypothetical family of four with an income of $50,000.

The worksheet included new information about the tax credit (compared to the brochure), specifically:

- how the amount of tax credit is tied to family size, income and the second lowest cost Silver plan; and
- how the tax credit amount is fixed, but can be applied to a variety of plans with the consumer paying the difference.

The worksheet showed how the tax credit–taken now and taken later—would work for up to three plans. A second page included a table that showed the expected premium contribution (as a percentage) based on family size and income.

EXHIBIT 6. WORKSHEET

How Much Tax Credit Do I Get?		Example	Your Family
A. Cost of an Efficient Plan for this Family			
Second Lowest Cost Silver Plan		Silver Lo Plan	
Yearly Cost of this Plan		$8,400	
B. Expected Family Contribution			
Family Size		2	
Yearly Income		$48,000	
Expected Family Contribution	as a percentage *from Income Table*	9.5%	
	in dollars	$4,560	
C. Tax Credit Amount			
Yearly Tax Credit (A – B = C)		$3,840	
Monthly Tax Credit		$320	

Whether you take the tax credit now or later, you pay the same amount for your health plan by the time you file your taxes.

How Does the Tax Credit Affect My Premium?				
If You Take It Now		**Plan 1**	**Plan 2**	**Plan 3**
Monthly Health Plan Cost	$ 700			
Minus Monthly Tax Credit *This amount is the same for any plan you choose*	– $ 320			
Your Monthly Payment	**$ 380**			
Yearly Cost of Coverage *Monthly Payment x 12*	**$ 4,560**			
If You Take It Later		**Plan 1**	**Plan 2**	**Plan 3**
Monthly Health Plan Cost	$ 700			
Full Cost of Yearly Coverage *Monthly Cost x 12*	$ 8,400			
Minus Yearly Tax Credit *This amount is the same for any plan you choose*	– $ 3,840			
Yearly Cost of Coverage	**$ 4,560**			

Ready to enroll? Call or visit your state's Health Insurance Marketplace.

The worksheet reinforces the "Take It Now" or "Take It Later" choice.

Nearly all participants were able to follow the moderator's verbal explanation and worksheet illustration. More importantly, they were able to compare the differences when the tax credit was applied to plans with varying premiums. Where the brochure had provided a general sense of the tax credit, participants were very eager to know exactly how much the tax credit would be for their family and what their final premium payment would look like.

With the worksheet, participants could get a concrete idea of the amount of tax credit they would receive, how the tax credit would be applied against a choice of three specific plans and the difference between the "Take It Now" and "Take It Later" options. For example, many participants were surprised by how much the tax credit lowered the monthly premium payment. As a result, a few who earlier in the interview had preferred the "Take It Later" option, now wanted to choose the "Take It Now" option.

> "I think we would probably take it now. I changed my position. I was leaning this way at first [take it later] and now I'm leaning this way [take it now] because it is hard to pay the bills already and it is a bit better to pay $163 than it is $900 every month. If the cost is really no different, then it seems a no-brainer to me." *Utah 007*

Perhaps, even more importantly, participants had a clearer sense that–over time–the tax credit was the same whichever option they chose. They also saw that their costs would change depending upon the plan they chose, but not the tax credit.

> "I would probably change my mind…I guess in black and white, it's the same amount of money either way…." *Oklahoma 004*
>
> "You still pay the same amount, but you don't pay the same amount at the same time. The tax credit, you would pay less monthly but at the end of the year, it would come out to the same*." Oklahoma 005*
>
> "Even though my family size is the same and my income is the same, my monthly [premium] may not be the same because Plan Five may be totally different from Plans One, Two, or Three." *Oklahoma 003*
>
> "Overall, I pay the same amount. I either get the money credited back to me–what I would have paid if I do the take it later. If I take it now, I still get the same amount." *Utah 004*

When asked about adding a new family member and the impact on their tax credit, nearly all were able to correctly respond that the tax credit would go up. All participants were able to use the table on the back of the worksheet to look up the expected family contribution (as a percentage) based on family size and income.

Participants were very eager to know exactly how much the tax credit would be and what their final premium payment would look like.

"I understand how this works now I think. The table is perfect. I love the table. That's easy cheesy. I can go –"Oh, that's me right there, I pay 4%." *Oklahoma 007*

"Depending on household size and your monthly income is how they can compute how much your credit is. It's your choice to take what money they give you in the credit to choose what your plan is, what you want." *Oklahoma 008*

Response of Enrollment Counselors and Tax Preparers

During the formative design stage, we conducted six interviews with experts in the fields of consumer tax assistance and health plan enrollment to inform the development of the tax credit brochure.[17]

- **Consumer Tax Counselors.** From these interviews, we wanted to learn the difficulties individuals have understanding tax concepts as well their suggestions for the best way to frame the Premium Tax Credit information for taxpayers.
- **Health Enrollment Counselors.** From these interviews, we wanted to learn the types of issues consumers may have with the advanced health care tax credit and hear their recommendations for explaining the concept to consumers.

Experts in the fields of consumer tax assistance and health plan enrollment said they would use the brochure with their clients.

During the usability testing phase, we sent these stakeholders an early draft of the brochure, timeline and worksheet, asking for their comments and if they would use these products with their clients. We also sent them a set of draft instructions describing how to customize and print the brochure.[18]

Brochure

On a scale of 1–5 with "1" being very confusing and "5" being very clear, all of our stakeholders rated the brochure a "4." Overall, they responded positively to the brochure and all said they would use it with their clients.

Elements they liked included:

- Good use of white space
- Colors
- Concrete steps
- Personal stories

[17] Three of the experts are independent accountants and tax preparers. The three health enrollment counselors hold various positions at Health Care for All (Massachusetts).

[18] These instructions are on the brochure website: consumersunion.org/tax_credit_brochure.

Elements they did not like included:

- Too much information
- Too many words
- Terms and phrasing could be simpler

Our testing showed that the brochure achieved a useful balance of information and we opted not to reduce the basic information in the brochure. Following up on their suggestions, we continued to edit the brochure to reduce the text and simplify phrasing whenever we could.

Timeline

Stakeholders liked the visual nature of the timeline and felt it would be a good, basic piece of information to hand out to consumers.

Worksheet

Stakeholders saw the value of the worksheet but indicated that they would like a set of instructions in order to use it effectively. These instructions will be posted on consumersunion.org/tax_credit_brochure along with the other materials.

Chapter 5. Conclusions and Recommendations

Not one of our participants had previously heard of the Health Premium Tax Credit. In addition, participants had little information about the Health Insurance Marketplace as a concept or as a reality. They had some awareness of the ACA with much of it based on hearsay and colored by political views. But even those who were somewhat hostile to ACA found the information in the Premium Tax Credit brochure helpful. By providing a minimal explanation of the Health Insurance Marketplace and indicating the source for the information, the brochure successfully helped participants understand the basic issues around the Premium Tax Credit.

Our testing demonstrated participants understood the Ten Critical Tax Credit Facts for Consumers, a key goal for the brochure.

Ten Critical Tax Credit Facts for Consumers

1. This is a tax credit program.
2. It will help you afford health insurance.
3. To participate, you must meet certain requirements. However, both lower and middle-income families can qualify.
4. You can use your tax credit only with insurance purchased from your state's new Health Insurance Marketplace.
5. You can take the tax credit in one of two ways with different benefits:
   - In advance, the tax credit lowers your monthly payments.
   - If not taken in advance, the tax credit lowers the amount of taxes owed or increases your refund at the end of the year.
6. Tax credit does not begin until 2014, but you can apply starting in October 2013.
7. If your income or family size changes, the amount of the final tax credit may change.
8. To ensure that any advance tax credit amounts are correct, you must immediately report income and family size changes to the Marketplace.
9. If you take the tax credit in advance and do not report changes, you may have to pay back overpayments.
10. You can get more information by contacting your state's Health Insurance Marketplace.

The brochure successfully helped participants understand the basic issues around the Premium Tax Credit.

Participants could correctly determine that they were likely to qualify and told us they would act on the information, most commonly by calling the Health Insurance Marketplace or visiting its website.

In addition, the worksheet, customized to their circumstances, provided additional information about the Premium Tax Credit and made it concrete for them. The worksheet also reinforced the notion that once taxes are filed, the tax credit is the same whether you take the credit in advance or at tax time.

Some of our participants assumed that our testing was connected to ACA or "Obamacare." As they moved through the booklet, the focus moved quickly away from the pre-conceived notions of "Obamacare" to the facts at hand. Although some remained resistant to the idea of the ACA, many people saw the Premium Tax Credit as a good thing and said they would apply. Most were surprised that the tax credit included an option that could help them lower the premium each month.

All of the documents we developed and tested were paper documents. However, many participants said that they would go to the web to find additional information. The worksheet was of particular interest to them as a tool they could use on their own on the Health Insurance Marketplace website.

Participants were surprised that the tax credit included an option that could help them lower the premium each month.

Recommendations

Our recommendations are primarily derived from the experience of interacting with consumers in two states that will be using the federally-facilitated Health Insurance Marketplace. Participants insights, opinions and understanding of the Premium Tax Credit are of value to Marketplaces and assistors (such as brokers and navigators), as well as state Departments of Insurance.

Our first three recommendations are primarily for the state and federal Health Insurance Marketplaces.

1. **Identify yourself as a government source.** Participants wanted to know the source of the information. They seemed to trust government more than private entities, even if they felt it was burdensome to deal with a government agency.
2. **Incorporate the key take-away points into navigator and broker training.** Our interactions with consumers were small, but telling. Consumers' pre-conceived notions, points of confusion and understanding of the Premium Tax Credit are likely to be repeated for assistors and others who interact directly with the consumers. Promoting the program as a middle-class program, using graphical timelines to augment verbal discussion, and other study findings to increase the value of these consumer interactions. Emphasizing an inclusive approach to consumer interactions, (*i.e.*, assume that consumers *will* qualify) will help ensure a positive consumer experience.

3. **Have a user-friendly and interactive website, featuring worksheet tools.** Participants expressed a desire to have tools, like the Tax Credit worksheet, as self-calculators. Some suggested a "chat" feature so that they could avoid calling but have the convenience of immediate assistance.

Our remaining recommendations apply broadly to all involved in conveying information about the new tax credits to consumers.

4. **Broadcast that the Premium Tax Credit is for middle-income families as well as lower-income.** Many participants were surprised by how high income could be to qualify. This fact alone often mitigated some of the hostility that some participants expressed toward health care reform.
5. **Emphasize that the Marketplace offers plans with good benefits and various premiums.** In the absence of this information, many participants assumed that few plans would be available and feared they would feature high deductibles and limited benefits.
6. **Be prepared for some confusion between Medicare and Medicaid.** In your consumer communications, don't assume that consumers can tell the difference between Medicare and Medicaid. Add explanatory text, if space permits. However, be aware that many key ACA concepts can be conveyed despite that confusion, as this brochure illustrates.
7. **Manage expectations regarding consumer burden.** Many participants liked the advanceable option for the tax credit for affordability reasons. But they worried that applying for it will be burdensome and that income changes might require a monthly check-in–also burdensome. If it can be truthfully reported that using the advance feature is not administratively burdensome, this fact should be highlighted to ease consumers' fears.
8. **Ensure a positive experience for consumers.** Participants want to have a positive experience when they enroll. At one level, this experience will come from friendly voices, accurate information and helpful assistance. At a deeper level, this experience will be driven fundamentally by whether the assistor who is helping is inclusive (*i.e.*, interacts with the consumer on the assumption that many consumers qualify) or exclusive (*i.e.*, interacts with the consumer on the assumption that many consumers do not qualify).
9. **Distribute the brochure widely.** The brochure was well-received by consumers. Based on our testing, the brochure explains the Premium Tax Credit in a clear and accessible way. Many thought it would be useful to have it in doctor's offices, but also suggested alternate locations, ranging from social services centers, libraries to grocery stores and gas stations.

We recommend using the brochure widely and incorporating key lessons into training curriculums for navigators and brokers.

10. **Promote the brochure, worksheet and timeline to brokers, navigators and others.** The products from this study can help brokers, navigators and other types of assistors in their work with consumers. The worksheet, in particular, was very helpful in getting participants to understand how the tax credit was calculated and reinforced that the combination of income and family was the basis for the contribution they would need to make. The worksheet also allowed participants to compare how the two options would affect their costs across different plans. Thus the tool not only explains, but can serve as a decision tool for them.

11. **Have accurate information available by phone and online.** Participants were mixed in terms of whether they would call or go online, but they would all want additional information about how to apply and what the bottom line numbers would be for their family. Participants expressed some concerns about interactive voice systems that could require excessive time on the phone to get information. Other participants wanted to be sure that online information was accurate and up to date. They expected tools like the worksheet to be on the website, so they could derive the bottom line numbers on their own.

Appendix A: About Testing

We used two types of consumer testing in Phase 2 and Phase 3.

Phase 2 Testing. We conducted two focus groups in Towson, Maryland. We grouped the participants by level of education. Each group answered general opinion questions about health insurance. They were then shown one of the two designs for the tax credit information and led through a series of debriefing questions. They then were shown the alternate design and debriefed on that design. Each group saw a different initial design. Their feedback was used to adjust the design and rethink aspects of it.

Phase 3 Testing. Two rounds of one-on-one cognitive interviews were used to obtain nuanced feedback on the two designs. One round was in Oklahoma City, Oklahoma and the other in Salt Lake City, Utah. We incorporated feedback into the designs between rounds. These cognitive interviews were organized around an unstructured "think-aloud," followed by a series of structured questions and comparisons of two different designs. In the final part of the interview, participants first reacted to a timeline option. Then the moderator used the worksheet to explain how the tax credit was calculated and to see the effect of the two tax credit options on three different plans. Participants then answered a series of questions about the worksheet.

In the think-aloud portion, the participant provided feedback based on what he or she noticed, but without questions on the part of the moderator. "Think alouds" allow the capture of the participants' inner dialogue as they interact with the tax credit products for the first time. The goal is to capture participants' reactions before they can "learn" from the testing situation and from the moderator's questions. In the structured portion, the moderator follows up with probes to answer specific, predetermined research questions and performance tasks, such as choosing which option to use for the Premium Tax Credit and articulating the logic behind the choice.

Appendix B: Detailed Demographics for Participants

Participants were literate English speakers recruited because they appeared to be eligible for the new tax credits. They were non-elderly adults with family incomes of 100% to 400% of the federal poverty level (FPL). Most participants did not have access to employer coverage and made health insurance decisions for their household. They were recruited to be evenly divided across:

- currently insured and uninsured,
- younger/older (young adults through 65)

We aimed for a diversity of gender, family size, race, ethnicity and education, but did not specifically recruit by these characteristics. Table B-1 shows additional detail.

TABLE B-1: DETAILED DEMOGRAPHICS

Gender	Male	10
	Female	6
Marital Status	Single	5
	Married or Partnered	8
	Separated or Divorced	3
	Widowed	0
Race	Black or African American	2
	White	12
	Asian	0
	Native Hawaiian or Pacific Islander	0
	American Indian or Alaskan Native	0
Hispanic/Latino	Yes	2
	No	14
Hispanic or Latino Origin	Cuban	0
	Mexican	2
	Puerto Rican	0
	South or Central American	0
	Other	0

TABLE B-1: DETAILED DEMOGRAPHICS (CONTINUED)		
Age	19–25	2
	26–30	1
	31–40	9
	41–64	4
	65 and over	0
Education	Less than high school, high school or GED	5
	Some college or a 2-year college program	6
	College graduate	2
	Post-college education	3
Household Income	Less than $30,000	6
	$30,000–$39,999	1
	$40,000–$50,999	6
	$60,000–$79,999	2
	$80,000–$99,999	0
	Over $100,000	1
If you were buying health insurance, how many people in your household would you put on a family plan?	1	5
	2–3	3
	4–6	8
How many people in the household all together?	1	1
	2–3	6
	4–6	11

TABLE B-1: DETAILED DEMOGRAPHICS (CONTINUED)		
What is your employment status?	I operate my own business	3
	I am employed full time outside the home	6
	I am employed part time outside the home	1
	I am a full time homemaker	1
	I am currently not employed, but I am looking for work	3
	I am not employed and I am not looking for work at the present time	1
	I am a full time student	1
	I am retired	0
Do you currently have health insurance?	Yes	8
	No	8
If you answered yes, how do you get your health insurance?	Through my employer	1
	Through my spouse's employer	1
	I purchase it myself	4
	Other	2
How do you typically prepare your taxes?	I use a paid tax preparer	9
	I use tax preparation software	3
	I use a free tax preparation/assistance program	1
	I get informal help from others	0
	Other	3

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Some Families Who Purchased Health Coverage Through The Massachusetts Connector Wound Up With High Financial Burdens

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ABSTRACT **Health insurance exchanges created under the Affordable Care Act will offer coverage to people who lack employer-sponsored insurance or have incomes too high to qualify for Medicaid. However, plans offered through an exchange may include high levels of cost sharing. We surveyed families participating in unsubsidized plans offered in the Massachusetts Commonwealth Health Insurance Connector Authority, an exchange created prior to the 2010 national health reform law, and found high levels of financial burden and higher-than-expected costs among some enrollees. The financial burden and unexpected costs were even more pronounced for families with greater numbers of children and for families with incomes below 400 percent of the federal poverty level. We conclude that those with lower incomes, increased health care needs, and more children will be at particular risk after they obtain coverage through exchanges in 2014. Policy makers should develop strategies to further mitigate the financial burden for enrollees who are most susceptible to encountering higher-than-expected out-of-pocket costs, such as providing cost calculators or price transparency tools.**

For individuals and families without access to employer-sponsored health insurance, or those with incomes too high to qualify for Medicaid, finding affordable coverage can be challenging. Enrollees' out-of-pocket premium costs in the nongroup insurance market can be substantial without an employer's contribution, and coverage in this market often requires high levels of cost sharing, increasingly through high-deductible plans.[1,2]

Financial burden resulting from out-of-pocket health care costs is more prevalent among people with private nongroup insurance than in any other group, including the uninsured.[3,4] High levels of cost sharing and the complexity of high-deductible plans may lead to problems paying medical bills and underuse of needed care.[5,6] Providers often do not realize that patients have problems with health care costs[7,8] that can lead patients to forgo both essential and nonessential care.[9]

Under the Affordable Care Act, states and the federal government are now creating health insurance exchanges to offer coverage to individuals and families who buy coverage on their own, as well as to small businesses. Exchanges are marketplaces with web portals where consumers will be able to search for insurance plans, starting with open enrollment on October 1, 2013, and are intended to provide health insurance options so that people can comply with the Affordable Care Act's individual mandate and avoid paying a tax penalty for remaining uninsured. As of February 2013 seventeen states and the District of Columbia had received approval from the federal government to operate a state-based exchange, seven states intend to

offer a state-federal partnership exchange, and the remaining twenty-six states have opted for a federally facilitated exchange.[10]

Plan offerings are organized into "metallic" coverage tiers (bronze, silver, gold, and platinum) based on increasing actuarial value—the percentage of health care expenses that health plans are expected to pay. Exchanges can reduce the cost of coverage for people purchasing insurance on their own by pooling large numbers of people together and thereby creating purchasing power, encouraging comparison shopping, and lowering search and overhead costs.

Enrollment is expected to be greatest in bronze and silver plans that have higher levels of cost sharing and deductibles than gold and platinum plans.[11] To keep out-of-pocket expenses as low as possible, people with annual incomes of less than 400 percent of the federal poverty level will be able to obtain federal premium subsidies to purchase coverage through exchanges, and those earning less than 250 percent of the federal poverty level will also be eligible for cost-sharing subsidies. By 2025 twenty-five million people are expected to be covered through exchanges.[12]

Massachusetts was one of the first states to create a health insurance exchange, called the Commonwealth Health Insurance Connector Authority. The Connector's Commonwealth Care program offers subsidized plans to people with incomes below 300 percent of poverty from carriers participating in the state's Medicaid managed care program. The Connector's Commonwealth Choice program offers unsubsidized plans in bronze, silver, and gold tiers from six commercial carriers, and it is similar to the proposed structure of exchanges under the Affordable Care Act.

The Affordable Care Act requires that exchange plans be categorized into metallic tiers based on actuarial value, which can be used by consumers to compare the generosity of health plans. The actuarial values for bronze plans in Commonwealth Choice are lower than those proposed by the Affordable Care Act (40–50 percent versus 60 percent, respectively) (Exhibit 1).[13] The Commonwealth Choice silver and gold actuarial values approximate those proposed in the Affordable Care Act (70 percent for silver and 80 percent for gold). In Massachusetts the majority of unsubsidized exchange enrollees have chosen bronze or silver plans.[14]

Given the cost-sharing requirements of exchange plans—that is, the various deductibles and copayments that may be required with the different metallic levels of plans—there is some concern about cost-related barriers for vulnerable populations, such as people with low incomes or chronic conditions and families with children. However, the prevalence of health care cost problems among families in unsubsidized exchange plans is unknown, as are the risk factors related to those problems.

In this study we examined the experiences of 393 families in unsubsidized Connector plans. Our goal was to identify families at elevated risk for financial burden because of health care expenses and for higher-than-expected out-of-pocket costs, and to identify factors that promote patients' discussions of out-of-pocket costs with doctors. We believe that knowledge drawn from these experiences with the Connector can inform the design of risk-mitigating strategies by exchanges in other states by identifying populations at risk for health care spending problems.

Study Data And Methods

DESIGN AND STUDY POPULATION We conducted a cross-sectional survey of families enrolled through the Massachusetts Connector in unsubsidized Commonwealth Choice plans from Harvard Pilgrim Health Care, a large nonprofit New England insurer. Harvard Pilgrim has participated in the Connector's Commonwealth Choice program since 2007 and has one of the largest market shares among commercial carriers in the Connector.[15] Exhibit 1 and online Appendix A provide details about the Commonwealth Choice plans' attributes.[16]

We used Harvard Pilgrim enrollment data to select families with and without children under age eighteen who had been enrolled in a plan through the Connector for at least six months as of January 2010. To have adequate numbers of families with children and families covered by plans without deductibles, we first selected all eligible families in plans with no deductible and then randomly selected equivalent numbers of families with and without children in high-deductible plans to reach a total of 800 families. High-deductible plans had annual deductibles ranging from $1,000 to $1,750 for individuals and from $2,000 to $3,500 for families. Of the 800 families, we selected a random sample of 650 families to survey.

DATA COLLECTION Between April and October 2010 we conducted a mailed survey with phone follow-up for nonresponders. We used Harvard Pilgrim enrollment and benefit data to obtain information on enrollee demographic characteristics, enrollment length, and plan attributes. Enrollees' geocoded addresses were used to link families to census-block-group socioeconomic data for the purpose of comparing respondents and nonrespondents. The study was approved by the Harvard Pilgrim Health

EXHIBIT 1

Benefit Structure Of Commonwealth Choice Plans In Massachusetts, 2010

	Plan tier		
	Bronze	**Silver**	**Gold**
Percent of all Commonwealth Choice Connector enrollees[a]	57	34	9
Percent of HPHC Commonwealth Choice Connector enrollees	60	35[b]	4
Actuarial value[c] (all Commonwealth Choice plans)	40–50%	63–75%	80–85%
LOWEST MONTHLY PREMIUM (ALL COMMONWEALTH CHOICE PLANS)			
Individual	$225	$313	$390
Family	$794	$966	$1,393
ANNUAL DEDUCTIBLE (HPHC PLANS)			
Individual	$1,500–$1,750	None or $1,000	None
Family	$3,000–$3,500	None or $2,000	None
ANNUAL OUT-OF-POCKET MAXIMUM (HPHC PLANS)			
Individual	$5,000	$2,000	None or $2,000
Family	$10,000	$4,000	$4,000
SURVEY RESPONDENTS (%)			
Unweighted	36	56	8
Weighted	53	44	4
PERCENT OF STUDY FAMILIES WITH ANNUAL INCOME <400% OF POVERTY			
Unweighted	55	49	45
Weighted	51	50	45
NUMBER OF CHILDREN <18 YEARS IN STUDY FAMILIES (MEAN)			
Unweighted	0.9	0.9	0.4
Weighted	0.3	0.6	0.4

SOURCE Authors' calculations using Harvard Pilgrim benefits data, enrollment and survey data for Harvard Pilgrim Health Care members, and Commonwealth Choice Plan data for 2010 from: (1) Massachusetts Division of Health Care Finance and Policy, Massachusetts health care cost trends: premiums and expenditures (Note 12 in text); (2) Massachusetts Division of Health Care Finance and Policy. Health care in Massachusetts: key indicators [Internet]. Boston (MA): The Division; 2010 Nov [cited 2013 April 8]. Available from: http://www.mass.gov/chia/docs/r/pubs/10/key-indicators-november-2010.pdf; and (3) Massachusetts Health Connector, Connector monthly summary report—March 2010 (Note 13 in text). **NOTES** Percentages may not sum to 100 because of rounding. For weighted results, analyses were weighted to reflect oversampling of families with children and those in plans without deductibles. HDHP is high-deductible health plan. HPHC is Harvard Pilgrim Health Care. [a]Excluding Young Adult Plans. [b]14% non-HDHP; 21% HDHP. [c]The actuarial value is the percentage of health care expenses that the health plan will pay for a standard population.

Care Institutional Review Board.

PRIMARY DEPENDENT VARIABLES The study's primary dependent variables were respondents' reports of any financial burden, higher-than-expected out-of-pocket costs, or discussions of costs with doctors. To measure financial burden, we asked enrollees whether, in the prior twelve months in the Connector plan, they or a family member had had problems paying or had been unable to pay medical bills; had had to set up a payment plan with a hospital or doctor's office; or had had trouble paying for other basic needs such as food, heat, and rent because of medical costs. An affirmative answer to any of these three questions was considered an indication of financial burden.

We asked enrollees, "Did your out-of-pocket costs in the Connector plan end up being as you expected?" We classified respondents who answered "No, actual costs were higher" as having higher-than-expected out-of-pocket costs. We also asked enrollees if they had discussed with their doctor or with their child's doctor the amount that they would have to pay for health care during the prior twelve months in the Connector plan.

INDEPENDENT VARIABLES We collected data on family sociodemographic characteristics, including health status and chronic conditions of the enrollee and his or her children (see Exhibit 2 for a list of specific conditions).[17,18]

ANALYTIC APPROACH All analyses were done at the family level. Bivariate analyses were done using chi-square and *t* tests. To identify characteristics associated with study outcomes, we first conducted bivariate tests of covariates that we thought a priori would be associated with the outcomes based on theory and existing evidence,[6,19,20] including parent age, sex, numbers of adults and children in the family, income, education, race or ethnicity, primary language, chronic conditions in adults and children, health status of adults and children, plan tier, high-deductible plan enrollment, and enrollment

EXHIBIT 2

Characteristics Of Study Families And Their Census-Block Groups, Massachusetts

	Respondents			Nonrespondents
Characteristic	**Unweighted *n***	**Unweighted %**	**Weighted %**	**Weighted %**
Family has child younger than age 18	176	45	24	23
Subscriber has college degree	253	65	64	—[a]
Subscriber is non-Hispanic white	352	91	92	—[a]
Subscriber's primary language not English	16	4	5	—[a]
ANNUAL INCOME AS PERCENT OF POVERTY				
Less than 300%	97	27	30	12
300–399%	84	24	20	—[a]
400% or more	173	49	50	—[a]
HEALTH STATUS				
Subscriber has fair/poor health status	32	8	6	—[a]
Adult in family has chronic condition[b]	159	42	39	—[a]
Child in family has chronic condition[c]	42	11	6	—[a]
INSURANCE TYPE OR STATUS				
At least one family member uninsured[d]	60	15	20	—[a]
Months enrolled in current plan (mean)	393	15	15	16**
PLAN TIER				
Bronze	141	36	53	47
Silver	220	56	44	48
Gold	32	8	4	5
HDHP	225	57	81	78
CENSUS-BLOCK GROUP				
Adults without high school diploma or GED (%)	—[a]	9.5	9.6	11.5
Hispanic (%)	—[a]	3.0	2.9	3.2
Black (%)	—[a]	2.2	2.3	3.1

SOURCE Authors' calculations using enrollment and survey data for Harvard Pilgrim Health Care members. **NOTES** Percentages may not sum to 100 because of rounding. Analyses were weighted to reflect oversampling of families with children and those in plans without deductibles. Significance is difference between respondents and nonrespondents. For respondents, annual unweighted median household income for census block group was $64,045; weighted was $60,154. For nonrespondents, annual weighted median household income for census-block group was $58,172. HDHP is high-deductible health plan. [a]Not available. [b]Abnormal uterine bleeding, arthritis, asthma, benign prostate enlargement, cancer, depression, diabetes, emphysema or lung disease, heart disease, or hypertension. [c]Asthma, attention deficit hyperactivity disorder; developmental delay; diabetes; depression, anxiety, eating disorder, or other emotional problem; or seizure disorder. [d]Prior to the family's enrolling in the Connector plan. $^{**}p < 0.05$

length.

For each of the outcomes, we then estimated multivariate logistic regression models that included covariates associated with the outcome at $p < 0.10$ in bivariate analyses. We excluded plan tier from the model of higher-than-expected costs because of that variable's collinearity with the high-deductible plan variable.

In this article we report results from these models as predicted probabilities of each outcome, using the study sample as the standard population. The significance of differences in predicted probabilities between groups was assessed using standard errors generated by a resampling method known as bootstrapping. We adjusted all analyses for oversampling of families with children and those without deductibles.

LIMITATIONS Because Massachusetts was one of the first states to have an exchange similar to those being implemented under the Affordable Care Act, our study offers some of the few data available to inform policy makers about enrollees' experiences in exchanges. However, our study was based on a single health plan in one state. Therefore, our results may not be generalizable to other plans or to states with different exchange designs or health insurance markets, or whose populations have different sociodemographic characteristics, than is the case in Massachusetts.

Our study population was also less socioeconomically diverse than the population of the uninsured and potential exchange enrollees nationally, especially lower-income enrollees who will be eligible for subsidies in exchanges in 2014. However, the characteristics of our study sample were similar to those of the larger Harvard Pilgrim Commonwealth Choice population and those of enrollees in unsubsidized nongroup plans nationally.[21]

Given that health care costs in Massachusetts are among the highest in the nation, the prevalence of financial burden in our study may be higher than in other states.[22,23] We could not determine how rates of financial burden and unexpected costs in our study population compared with those of enrollees in subsidized exchange plans, enrollees in nongroup plans outside exchanges, or the uninsured.

Our survey was unable to measure precise household income and eligibility for subsidized plans. Self-reported income often underestimates actual income, especially for those with incomes well above the federal poverty level. However, the error is relatively modest for estimates of wages and salary,[24] the most likely income source for people near the eligibility criteria for subsidized Connector plans.

Finally, our sample size of 393 families limited our power to detect other possible predictors of study outcomes, especially within the subgroup of families with incomes greater than 400 percent of the federal poverty level—those who will be most similar to enrollees in unsubsidized exchange plans nationally in 2014. Even so, we identified a number of significant factors associated with cost-related difficulties for our full study sample. In addition, the subgroup with incomes greater than 400 percent of the federal poverty level has characteristics similar to those of the population with lower incomes, except that families with the higher incomes are significantly less likely to have a subscriber in fair or poor health and to lack a college degree.

Study Results

The final study sample included 393 Connector enrollees, for a response rate of 61 percent. The characteristics of respondents and nonrespondents were not significantly different from each other except that respondents were significantly more likely than nonrespondents to be female, have more children, and have been enrolled for a shorter length of time (Exhibit 2).

After adjustment for oversampling of families with children and nondeductible plans, the distribution by plan tier was 53 percent bronze, 44 percent silver, and 4 percent gold (Exhibit 2). The distribution approximated that of the overall Harvard Pilgrim Connector population, which was 60 percent bronze, 35 percent silver, and 4 percent gold. The distribution also approximated that of the larger Commonwealth Choice Connector population—exclusive of Young Adult Plans—which was 57 percent bronze, 34 percent silver, and 9 percent gold (Exhibit 1).[14]

The weighted percentages of families with incomes of less than 400 percent of poverty ranged from 45 percent in gold plans to 51 percent in bronze plans, and the mean weighted number of children in the family ranged from 0.3 in bronze plans to 0.6 in silver plans (Exhibit 1).

UNADJUSTED ANALYSES Exhibit 2 shows some of the characteristics of our study sample. The large majority of enrollees were non-Hispanic whites. In weighted analyses, a quarter of the families had children, and half had incomes at or greater than 400 percent of poverty. Surprisingly, 30 percent had incomes below 300 percent of poverty, which would have made them eligible for subsidized plans in Massachusetts. In addition, the majority of respondents had a female subscriber, and 36 percent did not have a college degree (data not shown).

Thirty-eight percent of families reported financial burden, and 45 percent reported higher-than-expected out-of-pocket costs (Exhibit 3). Families with incomes below 400 percent of the poverty level were more likely than families with higher incomes to report both financial burden and higher-than-expected costs. Families with bronze plans were less likely to report financial burden but more likely to report higher-than-expected costs, compared to families with silver or gold plans.

A minority of enrollees reported discussing out-of-pocket costs with their own or their child's doctor (26 percent and 22 percent, respectively; data not shown). Enrollees reporting financial burden were more likely to have discussed costs with their own doctors compared to

EXHIBIT 3

Unadjusted Percentages Of Financial Burden And Higher-Than-Expected Out-Of-Pocket Costs, By Group, Massachusetts

Group	Prevalence of financial burden among respondents	Prevalence of higher-than-expected out-of-pocket costs among respondents
Overall	38	45
ANNUAL INCOME		
Less than 400% of poverty	56****	53**
400% of poverty or higher	24	39
PLAN TIER		
Bronze	31**	50**
Silver	47	43
Gold	34	13
PLAN TYPE		
HDHP	38	48***
Traditional	37	33

SOURCE Authors' calculations using enrollment and survey data for Harvard Pilgrim Health Care members. **NOTES** Analyses were weighted to reflect oversampling of families with children and those in plans without deductibles. "Financial burden" is problems paying medical bills; having to set up a payment plan with a hospital or doctor's office; or having trouble paying for basic needs such as food, heat, or rent because of medical costs, all within the prior twelve months. "Significance" is differences in outcome across a characteristic. HDHP is high-deductible health plan. **$p < 0.05$ ***$p < 0.01$ ****$p < 0.001$

enrollees without burden (42 percent versus 16 percent, respectively; $p < 0.01$), but not more likely to have discussed costs with their child's doctor (23 percent versus 20 percent; $p = 0.61$).

ADJUSTED ANALYSES

▶**FINANCIAL BURDEN:** The odds of financial burden were significantly greater when families had larger numbers of children, subscribers in fair or poor health, or incomes less than 400 percent of poverty (Appendix B).[16] The odds were significantly lower for people with bronze plans, compared to those with silver or gold plans.

The predicted probability of financial burden was greater for families with incomes below 400 percent of poverty than for families with higher incomes (61 percent versus 29 percent; $p < 0.01$). This higher probability of financial burden was also the case across family sizes (Exhibit 4).

▶**UNEXPECTED OUT-OF-POCKET COSTS:** The odds of having higher-than-expected out-of-pocket expenses were significantly greater for families with high-deductible plans, older subscribers, a larger number of children, and an income below 400 percent of poverty (Appendix C).[16] The predicted probability of higher-than-expected costs was greater for families with incomes below 400 percent of poverty compared to families with higher incomes (53 percent versus 37 percent; $p = 0.02$). Again, this probability of higher-than-expected expenses was also the case across family sizes (Exhibit 4).

▶**DISCUSSION OF COSTS WITH A DOCTOR:** The odds of an enrollee's discussing costs with his or her doctor were significantly greater when an adult in the family had a chronic condition (Appendix D).[16] The predicted probability of discussing costs was 36 percent for such families, compared to 23 percent for families without an adult who had a chronic condition ($p = 0.038$). The odds of the subscriber's discussing costs with his or her doctor were also higher for subscribers with two children than for those with none (36 percent versus 23 percent, respectively; $p = 0.008$). There was also a pattern of higher odds of discussing costs if the enrollee had fair or poor health or was nonwhite.

The odds of a subscriber's discussing costs with a child's doctor were greater for enrollees in fair or poor health and for those with a larger number of children (Appendix E).[16] The associated predicted probabilities were 50 percent for families with an enrollee in fair or poor health compared to 22 percent for families with an enrollee in excellent, very good, or good health ($p = 0.062$), and 25 percent for families with two children compared to 19 percent for those with one child ($p = 0.04$).

▶**FAMILIES WITH HIGHER INCOMES:** Starting in 2014 the population in unsubsidized plans available through exchanges will consist largely of people with incomes above 400 percent of the federal poverty level, because premium subsidies will be available to people with lower incomes. In analyses of families in our study with incomes greater than 400 percent of poverty, we found patterns related to risk factors for financial burden and higher-than-expected expenses that were similar to those we had seen in the full study sample. For example, families with worse health and more children had increased odds of financial burden and higher-than-expected expenses.

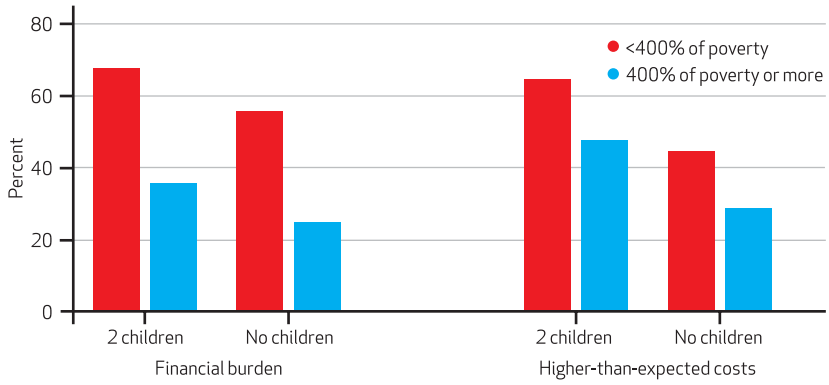
The sample size limited our power to detect significant differences in the characteristics associated with financial burden and higher-than-expected expenses among families with incomes above 400 percent of poverty. However, it is worth noting that in the higher-income group, we did not see increased odds of higher-than-expected expenses among people with high-deductible plans compared to traditional plans, as we did in the larger sample.

Discussion

This study is one of the first to evaluate the prevalence of and risk factors for financial burden and unexpected costs among families in unsubsidized health insurance exchange plans. Among families in such plans, those with lower incomes, worse health, and more children were

EXHIBIT 4

Predicted Probabilities Of Financial Burden And Higher-Than-Expected Out-Of-Pocket Costs Among The Study Group, By Income And Number Of Children, Massachusetts



SOURCE Authors' calculations using enrollment and survey data for Harvard Pilgrim Health Care members. **NOTES** The financial burden model controls for number of children, subscriber with fair or poor health, adult in the family with a chronic condition, child in the family with a chronic condition, income, and having a bronze plan. The higher-than-expected costs model controls for number of adults, number of children, subscriber's age, adult in the family with a chronic condition, child in the family with a chronic condition, income, and having a deductible plan. All comparisons by income for financial burden and by number of children for higher-than-expected costs are significant at $p < 0.01$. All comparisons by number of children for financial burden and by income for higher-than-expected costs are significant at $p < 0.05$.

at greater risk for financial burden and higher-than-expected out-of-pocket costs. Families in high-deductible plans were also more likely to have higher-than-expected costs than were families in plans with no deductible.

In addition, as the number of children in the family increased, enrollees were more likely to discuss out-of-pocket costs with their own or their child's doctor. Having an adult family member with worse self-reported health or a chronic condition also increased the likelihood that an enrollee had discussed costs with a doctor.

Levels of cost sharing and deductibles can be considerable for families purchasing plans through exchanges.[11] Although exchanges may expand access to coverage, financial barriers related to out-of-pocket costs could deter enrollees' use of needed health services. Sicker populations with greater health care needs are especially at risk for being effectively underinsured.[25,26]

Bronze and silver plans have been the most popular of the unsubsidized plans in the Massachusetts Connector, accounting for more than 90 percent of enrollment (exclusive of Young Adult Plans),[14] and they are also likely to be popular offerings in exchanges nationally in 2014.[11]

High-deductible plans are common in the bronze and silver tiers, and families will need to be aware of the magnitude of potential health care costs in such plans. High-deductible plan enrollees in our study had increased risk of unexpected out-of-pocket costs. Also, in other studies, enrollees in such plans have been found to unwittingly incur high costs because of confusion over which services are subject to the deductible.[27,28] The Affordable Care Act requires that health insurance exchanges include cost calculators to help consumers estimate their likely out-of-pocket expenses.

Ideally, providers' input should inform patients' decisions about delaying or forgoing care because of cost. However, our study and others have found that patients and their providers infrequently discuss out-of-pocket costs.[8,29] Patients may not have an opportunity to discuss costs with their doctors if high cost sharing leads them to forgo office visits.

We found that compared to those in better health, enrollees in worse health were more likely to discuss costs, perhaps because they had more frequent contact with doctors or because they were also more likely to experience financial burden. However, the majority of families in our study who reported financial burden did not discuss costs with their providers.

Providers should be aware that their patients may have remained silent about health care cost problems that could affect patients' adherence and use of recommended care.

Policy Implications

Identifying, monitoring, and addressing affordability and cost-related problems will be important for policy makers implementing exchanges. The risk of financial burden for families in the exchanges may be mitigated by Affordable Care Act policies to be implemented in 2014.

With actuarial values set by law at 60 percent, bronze exchange plans may cover a greater proportion of health care costs than the Connector bronze plans in our study, which had actuarial values of 40–50 percent.[13] In 2014 exchanges will offer premium subsidies for people whose incomes are less than 400 percent of the federal poverty level and cost-sharing subsidies to people whose incomes are less than 250 percent of the federal poverty level. Similar subsidies could have helped the 70 percent of families with financial burden in our study whose incomes were less than 400 percent of poverty.

Our findings are most relevant to families with incomes at or greater than 400 percent of poverty who will enroll in unsubsidized exchange plans after 2014. Almost a quarter of our respondents in this population experienced financial burden, and 39 percent reported higher-than-expected out-of-pocket costs (Exhibit 3). Our findings also have relevance to exchange enrollees in 2014 with incomes between 250 percent and 400 percent of poverty, as these people will not be eligible for cost-sharing subsidies (although they will be eligible for the premium subsidies). Those with incomes of 200–300 percent of poverty with increased health care needs will be at particular risk in the exchanges after 2014.[30]

In addition, not all eligible families obtain subsidies. In our sample 30 percent of unsubsidized plan enrollees, who made up 45 percent of those reporting financial burden, had incomes that would have qualified them for subsidies in the Connector. Some families may have consciously chosen unsubsidized plans to obtain coverage from a particular commercial carrier, to bridge a gap in employer-sponsored coverage, or because they had an employer who paid part of their premium. However, lack of awareness or confusion about plan choices may have led some eligible families to miss enrolling in subsidized plans.

Given the complexity of health insurance choices and consumers' limited understanding of health insurance benefits,[28,31] policy makers will need to provide outreach and simplified information to promote optimal plan choices.

Finally, our finding of decreased risk of financial burden for families in bronze plans raises the question of whether healthier enrollees are selecting these plans while sicker enrollees choose other plans. If that is the case, this skewing of enrollees would suggest the need for risk adjustment and other policies to protect exchange plans against unequal risk selection.

Conclusion

Financial burden and higher-than-expected costs are common among families with unsubsidized exchange plans in Massachusetts, especially those families with low incomes or children. In implementing the Affordable Care Act, policy makers will need to develop strategies to mitigate financial burden and facilitate discussion between patients and providers about the value of health care choices. Cost calculators or other tools to provide out-of-pocket cost information could help enrollees anticipate potentially burdensome costs, and discussions with providers could help them understand whether lower-cost alternatives are possible or whether the service could safely be forgone. ■

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16 To access the Appendix, click on the Appendix link in the box to the right of the article online.

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In this month's *Health Affairs*, Alison Galbraith and coauthors report on their survey of people who signed up for health insurance plans offered through the Massachusetts Commonwealth Health Insurance Connector Authority, a precursor of the exchanges created under the Affordable Care Act that will open for business in October 2013. The authors found that many families who signed up for unsubsidized coverage had high levels of financial burden and higher-than-expected costs—and that the phenomenon was especially pronounced for families with greater numbers of children and incomes below 400 percent of the federal poverty level.

The authors reason that more Americans may find themselves in similar situations as exchanges come on line in other states. They suggest that policy makers should develop strategies, such as the use of cost calculators or price transparency tools, to mitigate the financial burden for enrollees who are most susceptible to encountering higher-than-expected out-of-pocket costs.

Galbraith is an assistant professor in the Department of Population Medicine at Harvard Medical School and the Harvard Pilgrim Health Care Institute, where she is also associate director of the Center for Child Health Care Studies. Her most recent work has examined health care use and experiences of families in high-deductible health plans. Galbraith earned a master's degree in public health from the University of Washington and a medical degree from the University of Rochester.

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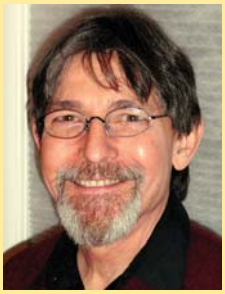

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The Oregon Health Insurance Experiment

In 2008, Oregon held a lottery to expand its Medicaid program. Research finds the first two years of coverage increased individuals' health care access and use, lowered out-of-pocket costs and medical debt, and improved mental health, but did not improve health in other areas.

May 2013

In 2008, with limited resources to expand its Medicaid program, Oregon determined a lottery would be the fairest way to choose enrollees. About 90,000 low-income adults applied for 10,000 openings. This overwhelming response allowed researchers to conduct the first randomized, controlled study of insuring previously uninsured adults.

The Oregon Health Insurance Experiment is providing clues to the likely impact of Medicaid expansion under the Affordable Care Act.

- Initial findings from the study, published as a National Bureau of Economic Research (NBER) working paper in July 2011, provided the first look at the Oregon experience after nearly a full year of enrollment. Researchers found that Medicaid coverage in Oregon increased individuals' health care access and use of services, lowered out-of-pocket costs, reduced medical debt, and improved self-reported health and well-being. They also found that Medicaid coverage did not reduce use of emergency departments, and annual health care expenditures increased by 25%.
- A second round of findings, published by the Oregon Health Study Group in the *New England Journal of Medicine* in May 2013, provided a look at the Oregon experience after two years. The researchers found that Medicaid coverage increased individuals' use of health care services, raised rates of diabetes detection and management, lowered rates of depression, and reduced financial strain. However, they also found no significant improvements in measured physical health outcomes in the first two years of Medicaid coverage.

This ongoing research, funded in part by CHCF, continues to advance understanding of the benefits and limitations of Medicaid coverage. The results also underscore the vital importance of finding ways to delivery care more efficiently.

Impact Award from AcademyHealth (February 2013)

The Oregon Health Insurance Experiment has been presented with the Health Services Research (HSR) Impact Award from AcademyHealth for being the first study to apply the gold standard of research — the randomized, controlled trial — to the questions of how having access to insurance affects utilization, personal finance, and health status.

Extrapolating the results of this small Medicaid expansion in Oregon to the very large expansion of Medicaid in California comes with important caveats. The relatively small number of new Medicaid enrollees in Oregon — an increase of less than 2% — means that constraints in the supply of primary care physicians were not a concern. The demographics of the uninsured population are also much different in Oregon than in California, and Medicaid programs differ in every state. For example, whereas Oregon Medicaid pays physicians 81% of Medicare rates on average, physician reimbursement rates in California's Medicaid program average only 51% of Medicare rates.

The complete *New England Journal of Medicine* Special Article is available as an External Link, and the NBER working paper is available as a Document Download.

DOCUMENT DOWNLOADS

The Oregon Health Insurance Experiment: Evidence from the First Year (423 K)

EXTERNAL LINKS

New England Journal of Medicine — The Oregon Experiment: Effects of Medicaid on Clinical Outcomes

By Alexander J. Ryu, Teresa B. Gibson, M. Richard McKellar, and Michael E. Chernew

The Slowdown In Health Care Spending In 2009–11 Reflected Factors Other Than The Weak Economy And Thus May Persist

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ABSTRACT During and immediately after the recent recession, national health expenditures grew exceptionally slowly. During 2009–11 per capita national health spending grew about 3 percent annually, compared to an average of 5.9 percent annually during the previous ten years. Policy experts disagree about whether the slower health spending growth was temporary or represented a long-term shift. This study examined two factors that might account for the slowdown: job loss and benefit changes that shifted more costs to insured people. Based on an examination of data covering more than ten million enrollees with health care coverage from large firms in 2007–11, we found that these enrollees' out-of-pocket costs increased as the benefit design of their employer-provided coverage became less generous in this period. We conclude that such benefit design changes accounted for about one-fifth of the observed decrease in the rate of growth. However, we also observed a slowdown in spending growth even when we held benefit generosity constant, which suggests that other factors, such as a reduction in the rate of introduction of new technology, were also at work. Our findings suggest cautious optimism that the slowdown in the growth of health spending may persist—a change that, if borne out, could have a major impact on US health spending projections and fiscal challenges facing the country.

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The recent slowdown in health care spending growth has become a focal point in policy debates. Average annual per capita national health spending grew 7.4 percent in 1980–2009, although the figure for the last ten years of that period was 5.9 percent. In 2009–11 the spending growth rate was down to 3.1 percent.[1] If this slowdown portends a new, lower level of spending growth, then dire forecasts of the national debt and additional taxes needed to support the health care system have been overstated. However, if the slowdown is temporary and growth returns to previous rates, then the need for policy changes to create a sustainable system is more pressing than it appears.

Whether the health care spending slowdown is temporary or permanent has been controversial. One school of thought holds that the slowdown is temporary, caused by lost insurance coverage and lower incomes stemming from the recent recession.[2–4] Some commentators in this camp point to the absence of new public or private structural changes that would keep health care spending growth low over the long term.[5] By extension, proponents of this view argue that if the approximately 3 percent annual increase in health care spending growth is indeed temporary, spending will probably resume its rapid growth as the economy improves.

Conversely, some have argued that structural changes have indeed occurred and that health care spending growth will be slower in the future.[3,6] In addition, a study conducted by Charles Roehrig and coauthors[7] found that the slowdown in spending growth began before the recession, supporting the notion of a more persistent change in spending growth that may remain even after the economy recovers.

Although health spending growth briefly accelerated in the early part of 2011, it subsequently diminished to levels consistent with the slowdown.[8] This trend led the Center for Sustainable Health Spending to conclude that the uptick of early 2011 was not a true return to high levels of spending growth.[8] Low spending levels persisted through the rest of 2011, resulting in a per capita spending growth rate of just 3.1 percent.[1]

There is no definitive evidence yet on whether the slowdown in health care spending growth is either temporary or permanent. The existing empirical evidence is largely based on time-series analyses and is insufficient to identify the factors that contributed to the slowdown and that will ultimately determine either its permanence or its temporary nature. Time-series analyses can be influenced by transient effects such as the insurance cycle[9] or randomly occurring fluctuations in health care spending. Although it is true that the slowdown in spending growth predates the recession, it is also the case that before the recession, spending growth was high, relative to the mid- and late 1990s. Perhaps what is being observed now is a rebound effect, in which high spending growth is falling back toward, or even below, the long-run average.

This study examined two factors that might account for the slowdown in health care spending growth during the recent recession: job loss and benefit changes that shifted more costs to insured individuals. Evidence that these factors were strongly associated with the slowdown would bolster the case for a return to more rapid spending growth. However, if job loss and benefit changes were not strongly associated with the slowdown, cautious optimism about the persistence of this trend may be warranted.

First, we focused on removing the effect of job loss in and policy changes affecting the public sector from the spending trend. Specifically, we examined spending by employees of large firms and their dependents. If the spending slowdown was the result solely of job loss and the associated loss of insurance coverage, then we would not expect to see a slowdown in spending growth among people who were continuously insured.

Second, we adjusted for changes in benefits that increased individuals' cost sharing and coinsurance. If the mechanism by which the recession slowed health care spending growth was through employers' reducing the generosity of benefits, which resulted in reductions in the use of health care services,[10] holding benefit generosity constant would produce a less rapid slowdown in spending.

Our analysis is not definitive because we examined a period of just five years, and in so short a time idiosyncrasies in spending could have an impact on our results. Nonetheless, in combination these two approaches will provide additional insights into the permanence or temporary nature of the slowdown in health care spending growth.

Study Data And Methods

DATA SOURCES For our analysis of spending by beneficiaries of large firms we used the 2007–11 Truven Health MarketScan Commercial Claims and Encounters Research Databases.[11] We focused on 150 large firms that provided data continuously throughout the study period. The data covered all fifty states and the District of Columbia, and the demographic composition of the databases was representative of people with employer-sponsored insurance. Used primarily for research, the databases are fully compliant with the Health Insurance Portability and Accountability Act of 1996.[12]

We defined *spending* as all reimbursements made to the provider of care—copayments, deductibles, insurance payments, and third-party payments (for example, for the coordination of benefits)—for inpatient medical, outpatient medical, and prescription drug services.

We excluded the 10 percent of enrollees who had claims paid by capitation because spending could not be measured accurately for those people. Also excluded were enrollees in health plans with fewer than 1,500 enrollees (another 10 percent) and those whose data did not include a plan type (<0.1 percent).

The unit of analysis was the enrollee-quarter, defined as the summarized experience of each enrollee in a calendar quarter. Enrollee-quarters in which the enrollee was not enrolled for at least twenty-seven days of each month were excluded. After these exclusions the sample contained 10,168,852 enrollees in 2007 and 12,171,728 enrollees in 2011.

METHODS We first compared growth in per enrollee spending in the MarketScan data to growth in aggregate per capita spending in the National Health Expenditure Accounts, which included spending on people covered by Medicare, Medicaid, or private insurance—either em-

ployer-sponsored or self-purchased—as well as the uninsured. Because we were interested in understanding trends in national health spending relative to trends that do not include the effects of job loss or changes in public-sector policy, we compared unadjusted National Health Expenditure Accounts trends to adjusted trends from large employers in which we used linear regression models to control for the effects of demographic characteristics (see online Appendix 1).[13]

The private employer data included only people with insurance. Thus, we expected these data to be less sensitive to the recession than the aggregate per capita National Health Expenditure Accounts spending data, which included the effects of people losing coverage. As a result, our analysis of adjusted spending growth in the large-employer data captured spending growth isolated from changes in coverage and policy changes in Medicare and Medicaid, such as the public sector's ability to cut reimbursements and the enrollment surge attributable to baby boomers.[14] Our adjustment for demographic characteristics also controlled for the effects of job loss and related changes in the composition of the workforce.

To investigate the effect of the change in cost sharing on spending growth, we added plan-level measures of benefit generosity to our regression model of private spending, using the MarketScan data (see Appendix 1).[13] Specifically, if employers reduced benefit generosity during the recession—for example, by increasing deductibles or coinsurance—some of the observed slowdown in large firms' spending growth would be the result of benefit erosion.

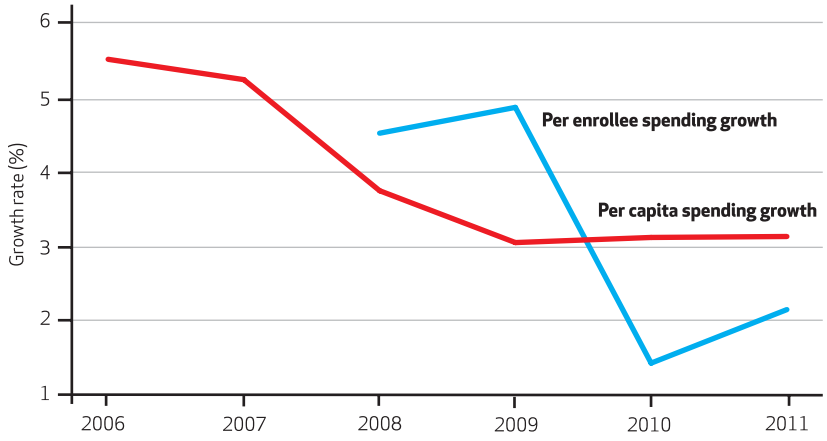
We measured the "generosity" of each plan in terms of cost sharing by computing plan-level annual mean out-of-pocket amounts—that is, coinsurance, copayments, and deductibles—per emergency department visit, outpatient visit, brand-name prescription, and hospital admission.

Study Results

COMPARISON TO NATIONAL HEALTH EXPENDITURE ACCOUNTS DATA Between 2007 and 2009 growth in health care spending in large firms was considerably more rapid than in the United States as a whole. This indicates that the effects of job losses over this period were likely incorporated into national spending trends overall, but not into spending for people with continuous coverage (Exhibit 1). However, in 2010 health care spending growth per enrollee per quarter in large firms plummeted. This drop in spending growth was greater in magnitude than what was observed in the aggregate per capita national data, meaning that spending growth was actually slower in the large firm data than in overall national health expenditures. Growth in the large-firm sample remained low in 2011, consistent with the observations of the Health Care Cost Institute.[15,16]

EXHIBIT 1

Health Spending Growth Per Enrollee (MarketScan) And Per Capita (National Health Expenditure Accounts), 2006–11



SOURCE Authors' analysis of data from Truven Health Analytics, MarketScan commercial claims and encounters research databases (Note 11 in text), and Centers for Medicare and Medicaid Services, National Health Expenditure Accounts (Note 1 in text). **NOTE** We calculated MarketScan annual growth rates by averaging spending across quarters in a given year.

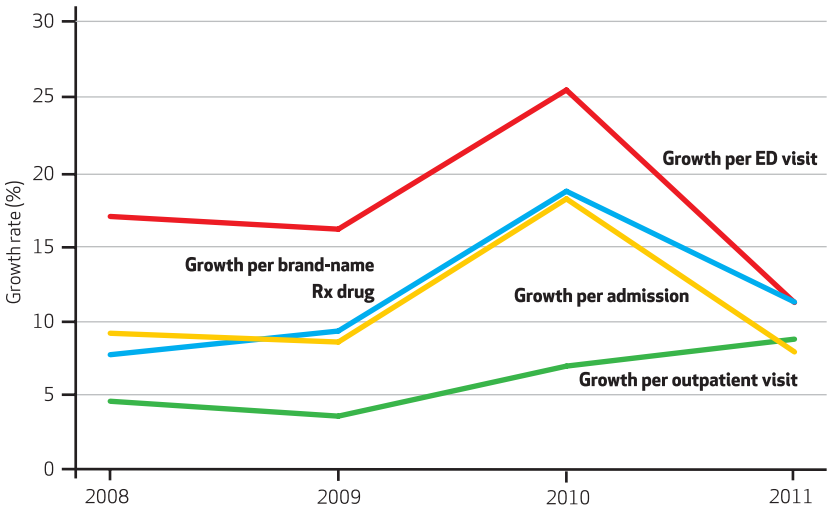
HOLDING BENEFIT GENEROSITY CONSTANT Cost sharing as measured by out-of-pocket payments rose during the study period, and the rate of decline in generosity increased in 2010 (Exhibit 2). Our observed acceleration of growth in out-of-pocket payments in that year, with a subsequent deceleration of overall out-of-pocket payment growth in 2011, was consistent with the findings of the Kaiser Family Foundation's 2012 annual survey of employer health benefits and the Health Care Cost Institute's cost and utilization reports.[15–17]

However, even when we held benefit generosity constant, the pattern of spending growth in large firms remained the same: no slowdown in 2008 and 2009, a rapid slowdown in 2010, and a slight acceleration of growth in 2011. But the magnitude of spending growth was affected by increasing out-of-pocket spending: When we did not adjust for changes in out-of-pocket spending, overall spending growth fell to 1.4 percent in 2010 and 2.13 percent in 2011 (Exhibit 3). The corresponding figures when we held out-of-pocket spending constant were 2.5 percent in 2010 and 3.0 percent in 2011.

These differences suggest that a change in benefit design that resulted in higher out-of-pocket expenses for enrollees partially accounted for

EXHIBIT 2

Growth In Out-Of-Pocket Health Spending Per Enrollee (MarketScan), By Type Of Service, 2008–11



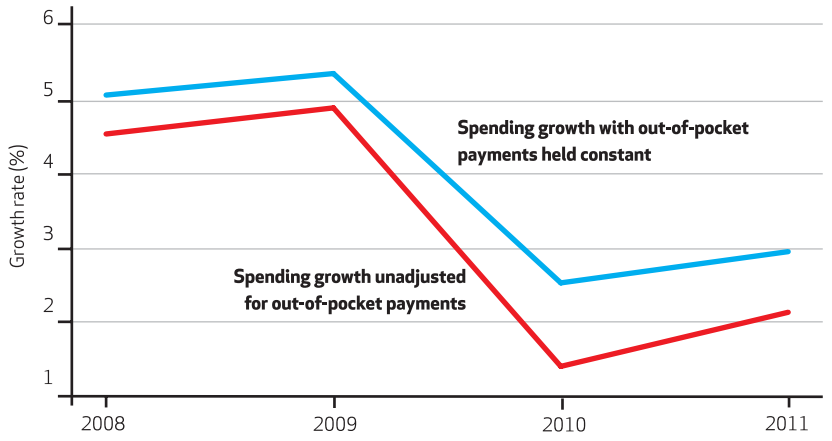
SOURCE Authors' analysis of data from Truven Health Analytics, MarketScan commercial claims and encounters research databases (Note 11 in text). **NOTES** All out-of-pocket payments are average payment per admission, prescription, or visit. Payments were scaled to begin at $100 in 2008 to eliminate scaling effects on spending growth. ED is emergency department.

slower spending growth. However, even when the effects of benefit design were removed, spending growth still fell substantially.

We could not determine whether the decline in benefit generosity was a result of the recession or of other factors, such as a long-term trend toward less generous benefits. However, at some point, benefit generosity is likely to stabilize, either because of unwillingness on the part of employees to accept worse coverage or because of the Affordable Care Act's actuarial value rules, which limit insurers' ability to shift costs to patients.[18] If generosity stabilizes, spending growth may rise again. Yet even when we held out-of-pocket spending constant, we found that spending growth in 2010 and 2011 was much slower than earlier in the decade. This slowdown may be a reflection of broader trends toward slower diffusion of technology or more fiscally conservative practice patterns by health care providers.

EXHIBIT 3

Health Spending Growth Per Enrollee (MarketScan), Adjusted And Unadjusted For Out-Of-Pocket Payments, 2008–11



SOURCE Authors' analysis of data from Truven Health Analytics, MarketScan commercial claims and encounters research databases (Note 11 in text). **NOTES** We calculated annual growth rates by averaging spending across quarters in a given year. The trend illustrating that spending growth with out-of-pocket spending held constant reflects a model in which out-of-pocket variables were included, as opposed to the base model in which we did not adjust for out-of-pocket spending. Mean person-quarter spending was approximately $1,150 in both adjusted and unadjusted models across the study period.

Conclusion

Our study found that health care spending growth even in large firms plummeted in 2010 and remained low through 2011. Rising out-of-pocket payments appear to have played a major role in this decline, accounting for approximately 20 percent of the observed slowdown. Nonetheless, we observed a slowdown in spending growth even when we held benefit generosity constant. Thus, our analysis of trends in National Health Expenditure Accounts data and large-employer data suggests that there has been a substantial slowdown in spending growth, even among those whose plans' benefit generosity has not changed.

However, our analysis was limited by our use of data from large firms only. As a result, we may have failed to detect trends that affected small firms differently. We were also unable to observe any changes in the policies of insurers or health care providers, other than those related to benefit generosity. If other initiatives (such as wellness initiatives or payment reform) generated one-time savings, we overestimated the slowdown. Moreover, we had data only through 2011, when the economy was still weak.

Nonetheless, we infer that the observed slowdown in national health care spending could persist in the future, consistent with time-series analyses.[7] In addition, health reform; changes in payment methodologies, such as the use of more global payments; and the transformation of the delivery system's organization could all have long-lasting effects. These trends, too, may cause the slowdown in spending growth to be more permanent.

Given the evidence from our analyses, we believe that current trends support cautious optimism that the spending slowdown may persist—a change that, if borne out, could have a major impact on US health spending projections and fiscal challenges facing the country, among other factors. ■

The authors gratefully acknowledge the support of the Robert Wood Johnson Foundation (Grant No. 70266) and the Program for Improving the Performance of Health Care Markets at Harvard Medical School.

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In this month's *Health Affairs*, Alexander Ryu and coauthors tackle the questions of whether the sharp slowdown in per capita national health spending growth from 2009 to 2011 represents a permanent or a temporary shift, and what may have caused it. Based on their examination of data covering more than ten million enrollees with health care coverage from large firms in 2007–11, the authors conclude that the increases in enrollees' out-of-pocket expenses, which would reduce workers' demand for health care, accounted for only about one-fifth of the observed decrease in the rate of spending growth. However, because the authors also observed a slowdown in growth when they adjusted for this trend, they infer that other factors have also depressed spending growth—and that the slowdown in the growth of health spending may therefore persist.

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BENDING THE CURVE

Person-Centered Health Care Reform: A Framework for Improving Care and Slowing Health Care Cost Growth



This project was supported by Robert Wood Johnson Foundation

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About Engelberg Center for Health Care Reform:

The Brookings Institution is committed to producing innovative policy solutions to our nation's most difficult challenges. The country may face no more important domestic policy challenge than the much-needed reform of our health care system. To help turn ideas for reform into action, the Brookings Institution established the Engelberg Center for Health Care Reform. The Engelberg Center's mission is to develop data-driven, practical policy solutions and recommendations that promote broad access to high-quality, affordable, and innovative care in the United States. The Center also facilitates the development of new consensus around key issues and provides technical support to implement and to evaluate novel solutions in collaboration with a broad range of stakeholders with the keen focus on reform that will improve not just the health care system, but the health of individual patients.

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EXECUTIVE SUMMARY

We propose a framework for health care reform that focuses on supporting person-centered care. With continued innovation toward more personalized care, this is the best way to improve care and health while also bending the curve of health care cost growth.

Our health care system holds great promise. As a result of fundamental breakthroughs in biomedical science, improvements in data systems and network capabilities, and continuing innovation in health care delivery, care is becoming increasingly individualized and prevention-oriented. The best treatment for a patient involves not just specific services covered under traditional approaches to health insurance financing, but also includes new technologies and new kinds of care and support at home in other settings different from traditional medical care. These advances require health care providers to work with patients and their caregivers to target increasingly sophisticated treatments and to coordinate care effectively ways that works best for each patient.

Our report's person-focused reforms aim to support these changes in care—not as an afterthought or as an addition to our health care financing and regulation, but as the core goal. Instead of having to work around fee-for-service (FFS) payments and regulations that can complicate getting the highest-value care in each case, providers and patients will be able to receive more support for the specific approaches to care delivery that can make the most difference. The support comes from aligning reforms in provider payment, benefit design, regulation, and health plan payment and competition. To avoid short-term disruptions, our systematic framework involves a clear path that builds on existing reforms in the public and private sector, supports transitional steps to assist providers, and includes close evaluation and opportunities for adjustments along the way. While our primary goal is better health through better care, we estimate that our reforms would achieve an estimated $300 billion or more in net federal savings in the next decade, and provide a path to sustaining per capita cost growth that is much more in line with per capita growth in Gross Domestic Product (GDP). After the proposed reforms are implemented in the coming decade, long-term savings from achieving better health and sustainable spending growth will exceed $1 trillion over 20 years. Our proposals can be scaled up or down, and can also be combined with other proposed reforms to achieve additional reductions in health care costs. Our approach enables Congress to focus on overall cost, quality, and access goals that are very difficult to address under current law—so that whatever the spending level, that spending will do more for health.

These issues of health care quality and cost must be addressed. If a clear framework like ours is not implemented, the alternative is likely to be continued reliance on short-term cost controls, including across-the-board cuts in payments like sequestration, or delays and restrictions in both needed coverage updates for vulnerable populations and new types of innovative care—perpetuating large gaps in quality of care.

Our proposals represent an alternative to such care disruptions, cost-shifting, and threats to more innovative, person-focused care. We include proposals for Medicare, Medicaid, and private health insurance. We also propose a set of system-wide regulatory reforms and other initiatives, including antitrust and liability reforms. While some of these proposals are specific to particular programs and regulations, they are all grounded in our core goal of supporting quality care resulting in lower cost. This means a clear path for moving away from FFS payments and benefits and open-ended subsidies for insurance plan choices toward a direct focus on supporting better care and lower costs at the person level. Our proposals encompass significant reforms—such as modifications in Medicare payment mechanisms and

benefits, and a change in the tax exclusion for employer-provided health insurance. The proposals reflect ideas that have gathered broad support in the past, but also include new approaches for addressing some of their shortcomings. Implementing our reforms together enables them to reinforce each other and create much more momentum for improving care while bending the cost curve.

Reforms for Medicare

» Transition to *Medicare Comprehensive Care* (MCC)

- MCC organizations include collaborations of providers that receive a globally capitated, comprehensive payment for their attributed beneficiaries and must meet a set of care quality and outcome performance measures for full payment.
- Structural requirements for these contractual organizations would be flexible; the organizations could include integrated systems or networks of providers working together.
- Providers would also be able to participate in MCC by accepting a case-based or bundled payment for their services and by meeting similar care quality and outcome performance standards for full payment.
- The initial benchmark for the MCC comprehensive payment would be set based on current beneficiary spending and quality of care, and the spending target will be increased over time according to a statutory limit on per capita growth (GDP plus 0 percent per capita). MCC providers would also be expected to sustain or improve quality of care over time, as reflected in increasingly sophisticated performance measures, facilitated by information systems used to support a beneficiary-level focus in care delivery.
- Providers can continue to receive traditional FFS payments, though those payments will likely continue to tighten over time and become less optimal for covering the costs of delivering effective care.
- Within 5 years, Medicare should offer beneficiaries the opportunity to choose MCC providers to receive their care. In conjunction with this choice, MCCs could offer beneficiaries incentives such as reductions in their Medicare premiums and/or co-pays.
- The MCC reforms would be phased in over 10 years with a set of milestones for measuring progress. By that time, we expect the vast majority of Medicare beneficiaries to be treated by providers who are paid using MCC methods.

» Reform Medicare benefits to support more comprehensive care and lower costs

- Medicare benefits would be updated to have an out-of-pocket (OOP) maximum and reforms in co-pays and deductibles similar to proposals by the Medicare Payment Advisory Commission (MedPAC) and other expert groups. These reforms would lower beneficiary costs on average and provide more protection. Medicare beneficiaries would also receive clear information about their OOP costs for different options for care.
- Medigap coverage would be reformed to eliminate "first dollar" coverage. This could be accomplished through a surcharge on Medigap plans that have average co-pays higher than 10 percent based on their additional costs to Medicare. Medigap plans would be able to offer lower co-pays for high-value services and providers.
- MCCs could offer lower co-pays and premiums for Medicare beneficiaries who choose to receive care from them.

» Reform Medicare Advantage to promote high value health plan competition

- Medicare Advantage payment updates would be the same as for MCC plans—that is, equal to GDP growth per capita, or less if overall Medicare spending grows more slowly.

- Medicare Advantage plans would be allowed to return the full difference between their bids and the benchmark to beneficiaries in the form of lower premiums.

» Use Medicare savings to create predictable payments in traditional Medicare and support the transition to MCC

- Specific elements of our proposed Medicare reforms would achieve over $200 billion in gross federal savings in the coming decade. Our framework calls for redirecting these savings within the Medicare program to support the transition to MCC models and provide a more predictable and sustainable long-term financing framework for Medicare. This includes reforming Medicare physician payment to replace the "sustainable growth rate" (SGR) with a payment system that increasingly includes elements of case-based payments, making similar changes in other FFS payment systems, and providing other incentives and support for the transition to MCC.

Reforms for Medicaid and Care for Vulnerable Populations

» Current state Medicaid waivers would transition to *Person-Focused Medicaid*, a standard process for states to implement Medicaid reforms

- The Centers for Medicare and Medicaid Services (CMS) would implement a long-term, system-wide strategy for *Person-Focused Medicaid* that includes extensive support, monitoring, and evaluation. This systematic approach would replace negotiating one-off waivers with states.
- This process would routinely track quality of care and per capita cost growth for Medicaid beneficiaries. States that improve quality of care and reduce per capita beneficiary cost trends would keep a disproportionate share of the savings (for example, 50 percent of the federal savings in our simulations).
- States would be encouraged to combine funding streams and to support innovative, efficient strategies for care delivery for both low-income uninsured populations and for dual-eligible beneficiaries.

» Medicaid reforms would be aligned with other initiatives and financial support for health care for lower-income individuals to facilitate care continuity and improve efficiency

- States and CMS would facilitate the participation of Medicaid managed care plans in state insurance marketplaces to help mitigate shifts in and out of Medicaid eligibility that disrupt both coverage and in how individuals receive their care.
- CMS would facilitate state reforms that coordinate funding streams and the delivery of services across programs to assist lower-income individuals (e.g., local safety-net initiatives and supports for mental health, Federally Qualified Health Centers, etc).

» CMS would make permanent and expand its "Financial Alignment Demonstration" for Medicare-Medicaid Enrollees into a reformed program for *Medicare-Medicaid Aligned Care*. This permanent, person-focused program would enable the development of a strong and systematic ongoing support, performance measurement, and evaluation capacity to provide a stronger foundation for effective and efficient comprehensive care for Medicare-Medicaid beneficiaries ("dual-eligible" beneficiaries)

- This permanent program would include a substantial quality improvement and evaluation infrastructure at CMS. The infrastructure would: 1) provide timely access to readily usable Medicare data on dual-eligible beneficiaries to the states and their provider and health plan partners; 2) produce more meaningful and consistent measures of quality of care and costs for dual-eligible beneficiaries; and 3) share evidence and best practices with states on effective steps for improving care for dual-eligible beneficiaries.

- Performance measures would include increasingly meaningful measures of quality of care as well as combined per capita expenditures across Medicare and Medicaid. States that improve performance and reduce overall cost trends would receive at least a proportionate share of the total savings (Medicare and Medicaid). State reforms that do not improve quality while lowering costs would be phased out, with increasing incentives over time for states to switch to effective programs.

Reforms for Private Health Insurance Markets and Coverage

» Limit the exclusion of employer-provided health insurance benefits from taxable income by imposing a cap that would grow at the same per-capita rate as federal subsidies in Medicare and the insurance marketplaces

- A cap on the employer-provided health insurance subsidy would be phased in over time by capping the exclusion at a high level initially (e.g., at the 80th to 90th percentile plan) and then indexing the cap by GDP growth once its subsidy value aligns more closely with other subsidy programs. This subsidy level would be designed to achieve significant health care savings from choosing lower-cost plans while still providing substantial incentives for employees to remain in employer-sponsored coverage.

» Encourage and support employer leadership in driving innovative reforms in health care coverage and delivery

- Support employer efforts to engage employees in reducing overall health care costs through Employment Retirement Income Security Act (ERISA) and other health plan regulations that promote value-based insurance designs and tiered benefit designs, narrow networks of providers that demonstrate high performance, and employees' ability to share in the savings from health care choices and changes in behavior that reduce costs.
- Promote transparency by making standard measures of provider performance available from Medicare and Medicaid that could be more easily combined with similar measures constructed by employers from their own data on health care costs and quality.
- Facilitate the adoption of payment reforms by providers in Medicare and Medicaid to match value-based payment reforms used by the private sector.

» Promote insurance market competition to support high-quality, lower-cost health plans, and that provides appropriate incentives for state regulation

- Implement regulations for the insurance marketplaces that allow flexibility in plan choices with actuarially equivalent benefit designs.
- All options would be required to meet meaningful minimum requirements for essential benefits for creditable coverage, but given the disparities in covered benefits across states, offset state-specific subsidy growth that is attributable to increases in the impact of state-required benefits over time.

» Facilitate stable non-group and small-group health insurance marketplaces by taking steps to reduce adverse selection and encourage broad participation for more affordable insurance

- Enhance participation through effective broad-based outreach and default enrollment for individuals who are eligible for subsidies.
- Limit open enrollment periods to one to two months per year.
- Impose limits on individuals' ability to shift from a plan with relatively low actuarial value to higher value (for example, allowing movement from a "bronze" to a "silver" plan in terms of actuarial value during open enrollment, but not a "bronze" to a "gold" plan).

- Relax the requirement for full community rating when consumers have not maintained continuous coverage and include late enrollment penalties (as in Medicare Part B and Part D).

Reforms for System-Wide Efficiencies

» Simplify and standardize administrative requirements to support higher-value care
  - Implement an updated standardized claim form.
  - Promote standard methods for quality reporting by providers and plans, including clinical, outcome, and patient-level.
  - Promote standard methods for timely data sharing by plans with health care providers and patients who are involved in our proposed financing reforms.
  - Provide further support for state investments to update their Medicaid information systems, including standard quality measure reporting and access to CMS data for quality improvement.

» Improve cost and quality transparency
  - Implement consistent methods across providers and payers for constructing quality measures and for plans to provide relevant out-of-pocket cost information (a core set of common measures and conditions, at minimum).
  - Require plans, as a condition of participation in insurance exchanges, to provide a common set of cost and quality measures—at the plan—and provider-level.
  - Restrict "gag" clauses.

» Promote effective antitrust enforcement
  - Require the ongoing production of a set of timely, comparable quality and cost measures at the level of major episodes of care and at the population level prior to integration and subsequently for clinical integration activities and mergers above a reasonable market-share threshold of concern. Failure to achieve improvements in quality and cost would be a foundation for subsequent antitrust action.
  - Update the antitrust enforcement framework to place greater emphasis on favoring clinical integration activities that are accompanied by financing reforms that move away from FFS payments and place providers at financial risk for quality gaps and higher costs.

» Address outdated licensing barriers for more effective and efficient care
  - Reform scope of practice laws to allow all health professionals to practice at the top of their licenses and capabilities.
  - Remove barriers to telemedicine services caused by state-specific licensing restrictions to enable licensing reciprocity.

» Encourage states to develop more efficient medical liability systems
  - Promote "safe harbor" or "rebuttable presumption" laws that establish legal protections for providers who achieve high quality and safety performance using valid measures.
  - Promote reforms that modify the existing judicial process for resolving tort claims with lower-cost and more predictable alternatives (e.g., a "Patient Compensation System").

» Enable states to implement system wide reforms
  - Use common performance measures and the MCC payment reforms to create a more straightforward pathway for Medicare to join in state-based financing reforms that have a "critical mass" of participants in a state including private plans, state/employee retiree plans, and Medicaid plans.
  - Provide enhanced opportunities for states to share in savings in Medicaid and Medicare that are generated as a result of state-led reforms affecting beneficiaries in these programs.

INTRODUCTION

We propose a framework for health care reform that focuses on achieving better care for each person, resulting in lower health care cost growth while promoting better health. Our proposals involve reforms across our health care system—Medicare, Medicaid, private health insurance markets, and important regulations like medical liability and antitrust rules. In all of these areas, we build on approaches that are already gaining traction but include new ideas that help them fit together better and that also avoid major short-term changes or disruptions in the care that patients receive.

Our report comes as the United States continues to struggle with major gaps in the quality and efficiency of health care, and as Congress and the Administration consider further steps to reform the federal entitlements and subsidy programs that account for the bulk of projected federal spending growth in the years ahead. More importantly, our report comes at a time of important breakthroughs in genomics, systems biology, and other biomedical sciences that are not only leading to better treatments, but also the prevention of disease and further complications based increasingly on each person's characteristics. These developments have been accompanied by improvements in data systems and network capabilities that make it possible to support and deliver much more personalized care that is customized to the needs and preferences of individual patients. Moreover, improvements in wireless and other technologies make it possible to prevent complications and deliver care at home and in other settings different from traditional medical care. Our reforms focus on supporting providers and patients in taking advantage of these innovations in technology and health care.

Our report also comes at a time when health care spending growth generally and Medicare spending growth in particular have slowed, and when some promising reforms are already being implemented in the private and public sector toward the goal of better, more personalized care at a lower cost. Consequently, now is a particularly good opportunity to implement reforms that are not disruptive in the short term, but can have a large impact on supporting improvements in care that can sustain slower cost growth in the longer term.

If there is not agreement soon on reforms like those we propose here, more aggressive steps will almost certainly be needed in the years ahead to achieve more urgent reductions in federal spending, like cuts in payment rates as in sequestration, or restrictions in coverage for vulnerable populations and in access to new types of innovative care.

Our proposals represent an alternative to such care disruptions, cost-shifting, and threats to more innovative, personalized care. They aim to achieve more sustainable health care cost growth through a comprehensive set of reforms in financing and regulation focused on supporting better care and better outcomes, and more value for our health care spending.

This reform proposal builds on the previous "Bending the Curve" reports that many of us authored (Bending the Curve: Effective Steps to Address Long-Term Health Care Spending Growth" and "Bending the Curve through Health Reform Implementation"). Our policy reforms fell into four major categories:

- Implementing an infrastructure of electronic data exchange, timely availability of quality and cost information, and better mechanisms to improve the evidence on quality and cost—which would be promoted by our other proposed changes;
- Changes in financing and regulation to support providers—including payment reforms tied more directly to value, liability reforms, and other supporting steps;

» Changes in financing and regulation to support consumers—including "value based" changes in insurance design and other incentives for wellness, improving health, and using care efficiently, along with resources to help consumers make those decisions; and

» Insurance market reform to promote coverage choices that would encourage higher-value care—including reforms in Medicare, Medicaid, employer-provided, and individual coverage choices that both provided adequate financial support for access to quality care, but also provided much more encouragement for people to choose plans that did more to keep costs down through innovations in provider payment and benefit design.

The second report updated these recommendations in light of the passage of the Affordable Care Act (ACA). We highlighted specific changes in Medicare, Medicaid, and private insurance systems.

Our framework and previous recommendations are summarized in Appendix Table 1. Important progress has occurred for many of those recommendations. There have been improvements in developing a better electronic infrastructure to support quality measurement and improved evidence; in addition, there have been changes to provider payment in Medicare and the private sector to increase the emphasis on value. For example, while accountable care organizations (ACOs) that track quality and patient-level costs represent only a fraction of payments (less than 20 percent), they are growing rapidly in both Medicare and the private sector. A range of other value-focused provider payment reforms besides ACOs are expanding, including medical homes for primary care and steps towards episode-based payments for specialty care. Indeed, today, a much larger share of providers view the shift in provider payment to value as a key feature of the future of health care and many providers have started to invest and reorganize accordingly, perhaps even contributing to the recent slowdown in spending growth. However, there is still considerable uncertainty about how and how fast value-based reform will grow. Some provider steps toward consolidation may be in response to uncertainties about health care reform and opportunities to obtain higher prices, rather than clear incentives to achieve better care. There is some promising anecdotal evidence on the impact of these reforms, but it is too soon to tell their overall impact on bending the cost curve, and system-wide measures of quality and access to care are not yet showing major improvements.

While there has been notable progress, much more needs to be done to improve care and achieve savings as a result. Consequently, we have worked together with additional co-authors to develop a new, updated set of reform proposals. Our collaboration was guided by the following principles:

» Placing the overarching concept of achieving better health and fewer complications at the *person* level at the center of health care reform, as the pathway to lower overall health care costs;

» Supporting this goal with aligned reforms in provider payment, benefit design, and health plan payment and competition;

» Describing the steps needed to move down this path, building on promising policy reforms being implemented now; and

» Monitoring progress along the way so that adjustments can be made as necessary.

Our proposals are driven by the persistent evidence of large gaps in the quality and safety of care, which lead to preventable complications and potentially avoidable costs, and of large gaps between the quality and cost of care that providers and consumers believe should be achievable in our health care system compared to what they often experience. Numerous studies have shown significant opportunities for improvements in care for all common and serious health problems in our health care system, particularly chronic diseases. There is also extensive evidence that changes in the way that care

is provided, particularly in how providers can work together to influence health care delivery. Steps that patients take—particularly when combined with better support for those steps—can also make a big difference. But with payment systems, benefit designs, insurance choice systems, and regulations that are more closely tied to the volume and intensity of care rather than its quality and value, it is not surprising that all these gaps and variations in quality and efficiency persist. Just as medical technology is moving toward a greater focus on putting together the right treatments for each patient, our health policies also need to do much more to support getting better results for each patient.

Table 1 illustrates some of the continuing opportunities for improving quality of care. In many cases, it is a challenge to even measure quality and outcomes consistently and reliably, in part because they have not been the direct focus of our health care policies. In contrast, it is relatively straightforward to track trends in the volume of medical services—the traditional basis for most health care payments. Nevertheless, our capacity to measure quality of care and health outcomes is continuing to improve, as is the evidence on how changes in health care delivery and patient engagement can achieve improvements in performance. Further attention and progress is needed, particularly for capturing quality at the person level for particular kinds of patients—such as people who are generally healthy with risk factors that should be managed; people with particular chronic diseases like diabetes, heart disease, or cancer; people who are considering major elective procedures like joint replacements or heart surgery; and people with complex or major illnesses, such as those with multiple chronic conditions or dementia. Appendix Table 2 illustrates some of the recent progress and expected next steps toward meaningful, patient-focused measures. Our financing and regulatory proposals will accelerate the capacity to produce such measures, and increase the attention for their improvements.

Table 2 highlights the related key focus of our reforms: using better support for improvements in care to reduce per capita spending growth in *all* of the major U.S. health care coverage systems. As the table notes, current law already provides some important pressure toward lower per capita spending growth over time, particularly in Medicare and in the subsidies for the insurance marketplaces. However, without further reforms to improve the delivery of care, many experts have expressed doubt that current-law limits on payment increases can be sustained. Our proposals take advantage of the opportunity created by slower cost growth in the short term to create a much stronger foundation for assuring that sustaining this slowdown does not compromise access or quality. For example, it will be difficult to sustain lower fee-for-service (FFS) payment updates in Medicare if they diverge over time from the cost of services or private sector payments, or if Medicare does not take further steps to support providers who are trying to change health care delivery to avoid preventable costs. It will be difficult to sustain coverage subsidies in the marketplaces that are held constant as a share of the Gross Domestic Product (GDP) if health care costs in other insurance systems accounting for much more coverage grow at significantly faster rates.

Table 3 summarizes our proposals. The proposals share the common goal of achieving lower spending growth through improving health care quality. They do so by providing a comprehensive approach to move steadily away from FFS payments and benefits and away from open-ended subsidies for insurance plan choices towards a direct focus on value—better care and lower costs—at the person level. Our presentation of these proposals is organized by program: Medicare, Medicaid, and private health insurance, including insurance purchased in the new marketplaces and insurance provided through employers. Our final section describes a system-wide set of regulatory and other initiatives, including antitrust and liability reforms. Some of these proposals are specific to particular programs and regulatory issues, but they are all guided by our core goal of better care at a lower overall cost for all Americans. While they encompass significant reforms—such as modifications in Medicare payment mechanisms and benefits, and a

change in the tax exclusion for employer-provided health insurance—they all incorporate ideas that have gathered broad support in the past and that build on promising trends in our health care system.

The proposals are intended to be a comprehensive set of steps, implemented incrementally, that would add up to fundamental changes over time to support better care. A key finding from evaluations of piecemeal, individual reforms and pilots intended to improve care and lower costs is that these reforms do not always work, and that when they do, they are often too small with too little infrastructure and momentum behind them to lead to substantial system-wide effects. Of course, that does not necessarily mean that larger-scale reforms will solve health care quality and cost problems. Consequently, in moving systematically beyond a wide range of pilot programs and tests, we take a step-by-step approach to permit course corrections and adjustments as further evidence accumulates. Together, these proposals are intended to give health care providers confidence about the direction and inevitability of reform that enables better planning and investment for improving care, while making sure that the steps along the way make real progress in getting better care and lower costs for patients.

In Medicare, our previous proposals supported payment reforms that are tied more directly to the value of health care, including ACOs, primary care medical homes, and bundled payments. While we continue to support all of these reforms, we propose a new comprehensive payment reform strategy for traditional Medicare that enables these payment reforms and others to fit together to achieve measureable reductions in overall Medicare cost trends while improving health outcomes. Similarly, we propose pathways to a systematic focus on person-level quality and overall costs in Medicaid, individual and small-group private insurance in the emerging marketplaces, and employer-provided coverage. All of these proposals move away from policies that provide open-ended government support for more costly care toward policies that give providers, insurers, and patients more savings when they improve care and lower costs. Similarly, we propose a set of reforms affecting the regulatory environment of health care and the electronic infrastructure for health care delivery that match our financing reforms.

Our approach has a primary focus on supporting providers and patients in improving care for the dollars we spend, and consequently, producing savings. As a result of implementing these reforms together, we estimate that our proposals could achieve $300 billion or more in "scoreable" net federal savings over the next decade, and additionally provide substantial resources for supporting the transition to a more comprehensive, beneficiary-level focus of care in Medicare. After the proposed reforms are implemented in the coming decade, long-term savings from better care and sustainable spending growth will exceed $1 trillion over 20 years. The proposed reforms can be scaled up or down to achieve more or less savings. They can also be combined with other reforms (e.g., changes in income-related premium subsidies or changes in eligibility for Medicare or Medicaid) that could achieve additional savings. Our framework encourages Congress to focus on overall quality and goals that are very difficult to achieve with resources available under current law and that enable our health care system and our health care spending to do more for health. Our most important objective is to achieve better care that can keep improving in the years ahead.

The President's budget and the House and Senate budget resolutions include targets for spending reductions in federal health care programs. All aim to reduce costs while maintaining or improving quality of care. Respected expert groups, including the Bipartisan Policy Center and Simpson-Bowles, have also put forward plans with savings estimates that range from $560 to $585 billion. These proposals have common elements with ours—particularly an emphasis on moving away from health care financing that is based on the intensity of care rather

than its quality and its ability to improve the lives of patients. They also include other reforms that could lead to additional savings, such as changes in income-related premium subsidies for Medicare or private insurance, or changes in eligibility for Medicare or Medicaid, or new price regulations. Many of us support these or other steps to achieve additional federal savings. However, we all believe that our framework should be the foundation for any reform, and we believe that all of the reform proposals illustrate the potential for a broad agreement on a framework for reducing cost growth by improving health care.

It is time for health care reform that does much more to support the movement toward the prevention-oriented, effective, and personalized care made possible by recent and coming technological innovations—thereby slowing spending growth without compromising access or quality of care. Our report is about how to get there.

REFORMS FOR MEDICARE

We propose that traditional Medicare transition from Medicare FFS to Medicare Comprehensive Care (MCC), in which Medicare financing becomes more closely aligned with the explicit goal of better, higher-value care for each beneficiary, measured at the person level. These reforms include changes to both payments and benefits that support a comprehensive approach to care for each beneficiary, while decreasing out-of-pocket costs by reducing complications and by helping beneficiaries get the care they prefer at a lower cost. Our approach builds on current Medicare payment reforms but provides a more systematic framework for implementation while ensuring the reforms have the intended effects on quality and cost at the beneficiary level.

Current law for Medicare includes important health policy reforms from the Affordable Care Act (ACA) that are expected to reduce Medicare cost growth. These include long-term limits on payment rate increases for providers in traditional Medicare and reductions in payments for Medicare Advantage plans towards the average cost of traditional Medicare. While these steps have been critically important to achieve short-term savings and lower future Medicare cost projections, they may turn out to be difficult to sustain if Medicare payments diverge from the cost of health care services. Further, these steps do not in themselves support providers who want to invest in more significant reforms in health care delivery to reduce costs and improve quality through approaches made possible by recent health care innovations. This is especially true for health care reforms that involve new sites of care (e.g., acute care centers rather than hospitals or physician offices), new types of services (e.g., telemedicine and smartphone-based services), new ways of identifying patients who are likely to benefit from particular treatments, new ways of coordinating care, and new approaches to promoting wellness and prevention of complications. Many of these innovative health care services, which may be highly valuable in the care of certain beneficiaries, are reimbursed poorly, if at all, in traditional Medicare.

Under the ACA, Medicare must achieve per capita spending growth of no more than GDP plus one percent (GDP+1) in the years ahead. If the Medicare actuaries project that such savings will not be achieved, the Independent Payment Advisory Board (IPAB) has the authority to make recommendations for further changes in provider payments (but not reductions in benefits or increased beneficiary cost sharing) to achieve that growth rate.

The ACA also supports a wide range of reforms intended to promote improvements in health care delivery—in response to widespread evidence of gaps in quality and coordination of care for Medicare beneficiaries that lead to substantial rates of preventable complications. These reforms include a set of new programs for ACOs that are accelerating, covering around 10 percent of traditional Medicare beneficiaries today, and are projected to more than double in the next several years. The ACO programs give providers the opportunity to share in savings when they achieve lower rates of overall Medicare spending growth per capita while improving on a set of quality and outcome measures for the beneficiaries for which they are accountable. The shared savings programs are intended to transition to "shared risk" and "partial capitation" programs in which the ACO providers receive increasingly capitated, risk-adjusted payments. In particular, participating ACOs in Medicare's Pioneer program are aiming to receive more than half of their reimbursement through performance-based, non-FFS contracts within three years. CMS also intends to transition providers in the Medicare Shared Savings Program to a shared-risk program after its first three years.

At the same time, the Center for Medicare and Medicaid Innovation (CMMI) is implementing a broad range of pilot programs for other provider payment reforms that are also intended to move payments from volume and intensity toward value. These include medical home payments for primary care providers, bundled payments for certain types of care involving hospitalizations, and state- and community-led payment reform initiatives. Similar ACO, case-based, and bundled payment reforms are becoming much more prevalent in private insurance contracts, and are growing in Medicaid as well. While many are showing encouraging results, evidence remains limited on their overall impact on reforming care delivery to reduce cost growth while improving quality.

The attention to piloting payment reforms reflects both the promise of these initiatives and the history that tightening FFS payments has not previously been a long-term solution to achieving slower spending growth. While slower short-term growth in Medicare costs has eased the short-term fiscal pressures facing the federal government, sustaining such slower growth has been difficult in the past, and many experts expect that spending growth will again accelerate. In addition, FFS payments provide less support than the alternative payment systems for improvements in care coordination, and implementation of more personalized and effective approaches to care delivery. Medicare's ACO program and its other payment reform pilots are promising steps towards aligning financing and delivery reform, but they are not well supported by benefits that help engage beneficiaries in better person-level care, and they do not yet amount to a comprehensive reform strategy.

Our "Medicare Comprehensive Care" framework puts these payment reforms together into a comprehensive strategy to accomplish the following: ensures beneficiaries get higher-quality, more coordinated care that reflects their needs; provides beneficiaries new opportunities to save money when they engage with their providers to receive better care; improves competition on overall cost and quality involving Medicare Advantage plans; and aligns with similar reforms that we propose in Medicaid and private insurance competition.

Medicare Comprehensive Care

Overview

Traditional Medicare should implement a transition from primarily FFS payment to Medicare Comprehensive Care (MCC), consisting of aligned payment systems for Medicare ACOs, medical homes, and episode-based payment bundles. These value-based payments for MCC providers would substantially (though not necessarily entirely) replace FFS payments over time, so that by 10 years from now, the vast majority of Medicare services would be reimbursed under MCC arrangements. This differs fundamentally from many other proposals for "capitated" payment reform, as the core of our reform proposal involves providers working together to achieve better care at the beneficiary level.

- MCC organizations would include sets of providers that receive a globally capitated, comprehensive payment for their attributed beneficiaries and must meet a set of quality and outcome performance measures for full payment. These contractual provider organizations could develop from current ACOs, building on today's Pioneer program, as more ACOs transition to organizations that accept partially or fully capitated global payments for Medicare services. Collaborations could also include contractual relationships with Part D plans. Providers working together as an MCC would not need to be fully integrated in order to receive MCC payment: many current ACOs include groups of primary care physicians who have non-exclusive collaborations with specialty providers and hospitals.

- Providers would also be able to participate in MCC by accepting case-based or bundled payment for their services and by meeting the same kinds of quality and outcome performance standards required for full payment. As we describe below, this will require acceleration in the rate of implementing case-based and bundled payment models in Medicare that achieve the same beneficiary-level costs as the capitated MCC payments.

- The initial benchmark for the MCC comprehensive payment would be set based on current beneficiary spending and quality of care, and increased over time according to a statutory limit on per capita growth. MCC providers would also be expected to sustain or improve quality of care over time, as reflected in increasingly sophisticated performance measures that they would report from the information systems used to support their beneficiary-level focus in care delivery. Under current law, the per capita growth rate cannot exceed GDP plus 1 percent. The President and House Republicans have previously proposed spending growth limits of GDP plus 0.5 percent per capita. We support GDP plus 0 percent per capita; with our Medicare payment and benefit reforms, we believe that improvements in the value of care delivery are possible to achieve that goal while sustaining and improving access and quality of care for Medicare beneficiaries. That growth rate is also consistent with current law Medicare spending projections for the near future; adopting it as the initial MCC benchmark would thus not be a big stretch and would help ensure that it is actually achieved through improvements in care. As a result of our reforms, instead of focusing on specific payment rule adjustments, a primary Congressional policy activity in the future would be to evaluate the adequacy of the spending growth rate against a much better array of meaningful measures of beneficiary quality of care. Those deliberations should be informed by ongoing reports from MedPAC and other experts regarding quality, access, and efficiency of beneficiary care, and recommended modifications in the spending growth rate.

- So far, Medicare beneficiaries have been informed when their providers adopt payment changes like ACOs, medical homes, and bundled payments, and they "participate" through their choice of providers (i.e., to determine provider payments, beneficiaries are assigned to providers based on their actual utilization of services). Within 5 years, and especially in conjunction with the Medicare benefit reforms we describe below, Medicare should offer beneficiaries the opportunity to choose MCC providers to receive their care. In conjunction with this choice, MCCs could offer beneficiaries reductions in their Medicare premiums and/or co-pays. We describe this approach in more detail when we turn to Medicare benefit reforms.

- Medicare would continue to offer traditional payments for providers not participating in the MCC arrangements, for as long as sufficient numbers of providers participate in the existing systems. However, the traditional payment rates must not exceed the same per-beneficiary cost projections that apply in the MCC program, and they are likely to become increasingly suboptimal to cover providers' costs using effective means of delivering care. We support incremental reforms in these traditional payments to

make it easier for providers to transition to and do well in the MCC system.

We expect that, with the transitional reforms described below, the vast majority of beneficiaries would be treated by providers who are paid using MCC methods in 10 years from now. Congress should establish milestones for the expansion of MCC payment availability and benchmarks for the performance of MCCs to help achieve timely progress toward the goal of promoting widespread availability of MCCs that are improving quality while achieving lower Medicare spending growth.

Structure of MCC Organizations

The structural requirements for contractual MCC organizations should remain flexible, as in today's Medicare ACO programs, allowing for health care providers to organize in the way best suited to delivering care in their specific community circumstances. For example, some existing Pioneer ACOs are fully integrated organizations, or at least headed in that direction. However, other ACOs are predominantly made up of primary-care and possibly other physician groups, that in turn coordinate their care with specialty providers and hospitals. Still other ACOs, like Optimus Healthcare Partners in New Jersey and Fairview Health Services in Minnesota, are contractual networks among multiple physician groups and hospitals that are not fully integrated, and instead rely on contractual arrangements for risk sharing and investments in data sharing and clinical systems to support overall accountability for the cost and quality of care for a population of patients. MCC organizations could also include collaborations involving acute-care or pharmacy clinics, primary care providers who receive medical home payments, and specialists and post-acute providers reimbursed on an episode basis.

Providers could also choose to participate in MCC by receiving payments on a case and/or bundled basis. As quickly as possible, CMS should phase in the availability of case or bundled payments for most of the providers' services. This could include a medical home payment for primary care providers or episode-based bundled payments for most of the services provided by specialists. The same kinds of performance levels on quality measures would be used in the bundled-payment MCC program. CMS would determine the specific payment and performance standards for this program based on input and evidence from providers, and the program should be designed so that a broad range of providers including solo practitioners and small groups could participate.

Transition to Medicare Comprehensive Care

In this section, we provide a more detailed overview of how the transition to Medicare Comprehensive Care could occur. Medicare's payment reform initiatives, including its ACO programs, pilots of medical home and episode payments, and other payment programs that involve reporting on quality, already support the transition to MCC payments. Growing pressures from limits on updates in traditional FFS payments, which result from current law, and our goal of improving care delivery to achieve more sustainable spending growth will also make these alternative payment arrangements increasingly attractive to providers. Under our proposed reforms, providers will have more support for adopting innovative approaches to deliver better care, more predictability in overall payments, and will be able to develop more experience over time as these payment reforms are phased in.

Establishing the Foundation for Medicare Comprehensive Care

» CMS must accelerate its efforts to implement and align meaningful performance measures in Medicare. MCC will require CMS to align the quality measurement foundations as the key building blocks of this program: the Patient-Centered Medical Home initiatives, Bundled and Episode-Based Payment initiatives, and ACOs. Measures would also be aligned between MCC organizations and Medicare Advantage plans.

» In particular, Medicare along with other payers should aim for a standard set of outcome-oriented payment measures for a range of beneficiaries: beneficiaries who have no major health problems but who may

have risk factors to manage, beneficiaries with common chronic diseases, beneficiaries with serious acute illnesses and who undergo major procedures, beneficiaries with major illnesses, and beneficiaries with frailty and multiple chronic conditions. This should also include the capacity to track low-income and minority beneficiaries. Many of these measures are in the process of implementation now, and many more could be, but they have not been put together yet in a comprehensive implementation plan.

» CMS must support providers in their evaluation of whether and how to move to MCC payments by sharing more usable, timely, and standardized data on a provider's beneficiaries, and facilitate the adoption of standard ways to summarize such data across Medicare's own payment systems and those of other payers. This approach would include measures based on Medicare's claims data of how the provider(s) would perform in a "virtual" MCC, including relevant bundled payment systems based on the beneficiaries attributed to them according to their utilization of care. Thus, a primary care provider could see how his or her group is doing on both medical home measures and on population measures for their beneficiaries; and a specialist could see how his or her group is performing on relevant episode measures, as well as on their patients' overall cost and quality of care. This would also include the ability for providers to look behind their summary measures to see opportunities to improve care for particular beneficiaries.

Implementing Medicare Comprehensive Care Payment Reforms

» Building on its current Medicare Shared Savings Program, Pioneer Program, and Advanced Payment ACO option, CMS would implement a pathway for MCC organizations to transition in the coming years to partial and full capitation for their assigned beneficiaries, in conjunction with an increasingly robust set of performance measures that the organizations would report. Organizations would need to meet performance standards to receive full payment.

» CMS would also implement a progressively expanding set of bundled payments with performance measures that are focused on common beneficiary health problems and common combinations of problems, along with primary-care case payments. Drawing on their experience and the experience of other payers as well, CMS would develop a clear model of how payment reforms affecting components of health care delivery, impacted by these complementary payment reforms, contribute to overall population health and costs.

» Instead of continuing in Medicare's traditional payment system, providers could opt to participate either in MCCs that are accountable for the quality and cost of a beneficiary's overall care, or in case- or episode-based bundled payments that replace traditional Medicare payments for these groups of services. ACOs would transition to person-level MCC organizations that receive a fully capitated payment for each beneficiary attributed to the organization. Providers who choose to participate in case- and bundled-payment options would similarly receive an increasing share of their payments through these arrangements—the vast majority of payments by a decade from now.

» In conjunction with reforms in Medicare benefit design, MCC providers could offer beneficiaries co-pay reductions or (in the case of beneficiary-level MCCs) lower premiums for receiving Medicare services through their systems.

Accompanying Reforms in Medicare's Existing Payment Systems

» To facilitate providers' transition to case-based and bundled payments as alternatives to fee-for-service payments, CMS would create and then expand elements of case- and person-level payments in each of its existing provider payment systems, as part of its continuing work to update these systems and to

ensure their accuracy. These payments would be accompanied by performance measures related to patient- or case-level quality of care and efficiency as described above, and would be designed to build upon and simplify Medicare's various current quality-related payment adjustments. Medicare has implemented quality reporting systems and payment adjustments for physicians, hospitals, and other providers. But these payments are generally administered as a variety of multipliers (adjusters) to all FFS payments to the provider. In contrast, shifting some existing FFS payments into partial use of case-based payments would give providers more support in moving toward medical homes, condition-based and other bundled payments, and comprehensive (capitated) payments that allow for more of a patient-level focus in care delivery but may otherwise be too big of a leap. New Part B payments for care coordination for primary care physicians, as well as proposals by physician specialty groups to replace some of their FFS payments with case-based payments (e.g., for a component of specialty services that are currently reimbursed on a FFS basis), are examples of steps in this direction.

» Under our proposal, overall per-beneficiary payments in Medicare's traditional program should grow no faster than GDP per capita. Under current law, this is not projected to require further tightening of existing FFS payments for five or six years. If further reductions in traditional payment rates are necessary in the future, they could occur through either the IPAB as in current law, or through an across-the-board reduction in payment updates. If such payment rates are inadequate for certain providers, Congress could adjust payments while finding offsets elsewhere. If evidence suggested that overall MCC and FFS payments were creating potential quality problems, Congress could increase Medicare's per capita benchmark growth rate, as noted above.

» The savings from our Medicare reform proposals, including the savings from transitioning traditional Medicare to a slower spending growth benchmark in the years ahead, would be used to provide significant additional financial support to providers for assisting in the transition toward MCCs and improvements in care delivery. This would include stabilizing Medicare's physician payment system with an alternative to the sustainable growth rate (SGR) that promotes better and better-coordinated care. It would also include additional support for providers who switch to MCC payments to assist them with start-up investments in practice reforms.

» Any changes in traditional Medicare FFS payments should not raise overall Medicare spending, but should promote the increasing use of case- and patient-level payments and provider participation in an MCC person-level or bundled payments. For example, physician payment reform should be part of a reform package that provides a pathway for physicians to move toward case-based payments for most of their services and that begins to enable physicians to share in the savings for care decisions they make that improve quality and reduce overall Medicare costs. Physicians who opt to shift to MCC might receive larger payment increases. Similarly, any new increases in payments for other providers would be paid for by offsetting Medicare savings and would not simply be across-the-board increases in FFS rates, but would include moving an increasing share of payments into case-based or bundled payments. For example, an increase in hospital payments because of concerns about inadequate updates could be linked to a hospital shifting an increasing share of its payments into partially bundled payments with other providers for episodes of care.

Administrative Reforms and Milestones for CMS to Support Medicare Comprehensive Care

» CMS should produce usable claims-based data in a timely and consistent way to providers. For quality measures that will come from MCC providers, CMS should support standard batch data reporting, ideally through direct submission from electronic systems

including electronic medical records and registries. Since these steps will make it easier for providers to participate in quality improvement efforts, these data flow enhancements should be a high priority for Medicare program administration. While these steps would require a significant enhancement of CMS data capabilities, they build on steps that CMS is currently taking and are necessary foundations for supporting providers in improving care.

» These steps will require CMS to shift much of its current demonstration and pilot program activity—particularly on medical homes, bundled payments, and other population-based payments—into supporting the steady and effective implementation of payment reforms in the traditional Medicare program. CMS should allow providers to participate in potentially reinforcing value-based payment changes with a primary focus on how the set of payment reforms affect overall outcomes and costs for beneficiaries. In particular, collaborating providers should be able to participate simultaneously in medical home, episode-based payments, and ACO initiatives with a total shared savings calculation based on their overall results, as in many private-plan initiatives today. These payment reforms should be a coordinated and reinforcing approach for steady progress toward improvements in care and associated reductions in cost growth at the case and beneficiary level.

Legislation supporting the transition to MCC should have milestones for CMS along the path for implementing case-based payments, to assure that the vast majority of providers are able to participate as MCC organizations or contribute equivalently to achieving quality and per capita spending benchmarks by 10 years from now. For example, within two years, Medicare might be required to implement case-based elements in each of its traditional payment systems where they do not exist already, and provide options for bundled payments for care affecting at least 10 percent of Medicare spending; in four years, these payment elements might be required to address 30 percent of payments; by ten years from now, the vast majority of payments would be covered by such systems.

Reform Medicare Benefits to Support Comprehensive Beneficiary Care and Lower Costs

Medicare benefits provide critical financial support for millions of Americans, but they are not well aligned with supporting steps that beneficiaries can take to engage with their providers and to receive high-value care at a lower cost. While private health insurance benefits and Part D benefits are also imperfect, they are increasingly set up in ways that enable beneficiaries to share in the savings when they reduce overall health care costs through value-based insurance designs or higher deductibles. In contrast, Medicare beneficiaries receive limited, if any, out-of-pocket (OOP) savings when they take steps to use less costly care in Part A and Part B, especially if they have supplemental insurance such as Medigap coverage. In our previous reports, we identified benefit reforms that would reduce costs for Medicare and provide better protection against high costs for beneficiaries. MedPAC has also considered benefit and Medigap reforms similar to our proposals. These steps require care in implementation, because in cases of low to moderate expenses, beneficiaries could pay more and face somewhat less predictability of expenses. However, all of our reforms would increase overall beneficiary protection against high costs. Further, these reforms would give beneficiaries new opportunities to reduce their OOP costs when they receive care from MCC providers that deliver better care. Combining these steps in Medicare benefit reforms would give beneficiaries a much better way to meaningfully participate in choosing MCC care, reduce beneficiary costs, and significantly increase the impact of payment reforms to providers.

» Medicare benefits would incorporate OOP maximum and more rational co-payments, as in reforms considered by MedPAC and others. Beneficiaries would have better information about their OOP costs for different options when receiving care. The MCC organizations described above will help achieve this goal by providing clear information on total and OOP costs for their bundles of services (or for all of a beneficiary's care), and CMS would

provide comparative OOP cost summaries as well. In conjunction with the more complete measures of quality and cost described above, Medicare should use the same framework of virtual cost measures (e.g., estimates of the costs associated with the overall episode of care from an elective-care specialist) to implement steadily improving information about the cost consequences of choosing providers who are not part of MCCs.

» MCC organizations should be able to offer lower premiums or co-pays for their sets of services for beneficiaries who choose to use MCC providers when the MCCs demonstrate lower actuarial costs (i.e., the MCCs can use their lower overall costs relative to the MCC benchmark to buy down premiums and co-pays).

» These OOP reforms will have only limited consequences for beneficiary savings without reforms in Medigap coverage. Medigap needs to be reformed, at least for future beneficiaries, to strongly discourage "first dollar" coverage that is unrelated to quality or value and that adds substantially to costs. Medigap plans should have an actuarially-equivalent co-pay of at least 10 percent, though plans should have actuarial flexibility in adjusting co-pays to promote higher-value care. This could be accomplished through significant surcharges on Medigap plans that do not meet these standards, perhaps phased in over a transition period, and could build upon proposals from the Administration, many members of Congress, and expert groups. Implementing these Medigap reforms in parallel to the Medicare benefit reforms reflects the close link between these two reforms and demonstrates how, together, they can reduce total beneficiary payments while providing better protections against high costs and promoting better care.

» Other co-pay reforms that better reflect the value of services and effective insurance protection should also be implemented, along the lines that MedPAC is considering.

These reforms would be implemented in a manner that does not increase beneficiaries' overall cost sharing, substantially reduces Medigap premiums, and improves beneficiary protection against high costs, all while enabling greater beneficiary engagement in improving care.

Reform Medicare Advantage for Higher-Value Competition

The reforms in traditional Medicare payments and benefits described above will provide greater certainty that the current law requirement of GDP+1 percent growth or less in per capita spending can be achieved and sustained. As we have noted, we believe that a lower spending growth of GDP+0 per capita can be achieved, through better and more systematic support of needed reforms in care delivery. Because Medicare Advantage (MA) plans also provide an important means for achieving higher-value care, we propose that MA plans report the same MCC performance measures and use the same per capita growth rates for their subsidies.

» The current-law formula for updating MA payments would be modified so that the same update for MCC plans (i.e., GDP+0 percent) would apply to MA plan subsidies. That is, both programs would receive the same per capita payment increases. Along with the MCC changes, this update would allow Congress to focus much more on beneficiary quality of care and value, as well as on a single per capita payment growth rate with regard to Medicare costs in both traditional Medicare and Medicare Advantage plans.

» MA plan requirements should be modified to allow plans to return the full difference between their lower bid and the benchmark to beneficiaries in the form of lower premiums, with no requirement that plans convert lower costs into additional actuarial value of benefits. Currently, plans can receive between .67 and .73 (depending on the Medicare Star rating) of the difference between the plan's bid and the case-mix adjusted benchmark. Under this system, plans often return this difference in the form of extra benefits. To encourage greater competition on price, we

recommend that Medicare return the full amount (i.e., 1.0) of the difference if provided in lower premiums, and 0.5 if provided in the form of additional benefits. This reform would be most effective alongside the reforms in Medigap and the traditional Medicare benefit structure that we have described, so that the standard Medicare benefit package represents a more modern benefit structure.

» Implementation of these steps should be accompanied by the collection of more extensive, outcome-oriented performance measures consistent in MA plans and traditional Medicare. As we have noted, such outcome-oriented measures will be available from the MCC initiatives in traditional Medicare, and can be constructed by CMS for all beneficiaries in an area. Better measures would make it easier to detect any significant selection issues between MA and MCC plans. These measures should also address the extent to which any increasing differences between MCC and MA plans are due to health status or socioeconomic status.

» The Medicare benchmark for payments to MCC and MA plans should grow more slowly if the total costs of Medicare benefits grow more slowly. In particular, CMS would calculate the average growth of total costs per beneficiary for Medicare benefits across both traditional Medicare and Medicare Advantage plans (i.e., the average of per capita total Medicare costs in MCC organizations). If this is lower than the benchmark growth rate, and if there is no evidence of substantially worsening adverse selection between traditional Medicare and Medicare Advantage, the growth in the Medicare benchmark for both traditional Medicare and Medicare Advantage plans would equal this slower cost growth rate. Spending on premium or co-pay buydowns and other reductions in cost sharing by MCC organizations and MA plans would not count in this calculation. The lower benchmark would directly reflect the lower cost of providing all Medicare-required benefits. This proposal differs from premium support proposals. It reflects slower growth in total costs of Medicare-required benefits and thus does not shift costs to beneficiaries, it happens only in the context of reforms that enable traditional Medicare to take steps to become significantly more efficient (i.e., MCC reforms), and it occurs only with ongoing and improving measurement and evaluation of quality of care for vulnerable beneficiaries.

REFORMS FOR MEDICAID AND CARE FOR VULNERABLE POPULATIONS

Medicaid currently covers over 50 million individuals, including more than 1 in 4 children and a growing number of the lowest-income, medically complex, and frail Americans. Eligibility is slated to expand substantially, particularly for low-income adults, beginning in 2014 under the ACA. While Medicaid is an increasingly important coverage source for Americans with limited means and high health care needs, cost increases are straining state and federal budgets, and challenges exist in access, coordination, and continuity of care.

State Medicaid plans in recent years have shifted away from traditional FFS Medicaid benefits and toward more person-focused coverage and care programs. States operate on "waivers" from standard statutory Medicaid benefit requirements in providing coverage with the general requirement that beneficiaries receive

care that is as good as the Medicaid statute requires at no more than the expected cost than would have been incurred under the statutory approach. This state-by-state, waiver-by-waiver approach is now the hallmark of Medicaid, and it typically involves substantial back and forth negotiation between states and the federal government in each case.

In this waiver-based system, there is a growing evidence base for comprehensive state waivers that enable savings and better care within a global spending cap. For example, New York has included a Medicaid global spending cap in its waiver that will grow annually with the medical Consumer Price Index (CPI). The focus on global spending makes it easier for New York to implement system-wide reforms like health homes and accountable-care payments. Arkansas' 2011 waiver, the Health Care Payment Improvement Initiative, sought to move from FFS to bundled payments, to support significant improvements in care that had not been possible under FFS. California previously implemented a "Bridge to Reform" waiver for some Medi-Cal beneficiaries in which per capita payments and payment increases to Medicaid health plans are capped, and is now implementing a much broader waiver using a similar model with an emphasis on beneficiary quality of care and per capita spending growth benchmarks. Oregon's proposed Medicaid waiver renewal includes a fixed global budget for their community-based Coordinated Care Organizations (CCOs), which have both accountability for beneficiary-level results and more flexibility in using Medicaid funds to provide care.

One reason that such waivers with per capita benchmarks are important is Medicaid's joint federal-state funding that splits Medicaid costs between states and the federal government. This basic structure means that the financial benefit to states for reducing spending growth—and the costs borne by states for increased spending growth—is limited despite the fact that states have the leading role in developing and implementing reforms in Medicaid coverage to improve health care for low-income residents. For example, even if states take steps to prevent complications and to improve the coordination of care for low-income beneficiaries—leading to lower costs because of fewer hospitalizations and other complications or other inefficient services—states receive only a fraction of the Medicaid savings and little of the hospital savings. Similarly, while the new Medicaid coverage expansions will provide needed coverage for millions more low-income adults, the very high federal match rate means that states will retain an even smaller share of savings when they undertake activities to improve the efficiency of care. While there are understandable concerns that states need oversight to assure that cost savings do not come at the expense of quality, the recent waivers show that it is possible to develop models that provide stronger support to states for innovations in care delivery to improve quality and achieve greater efficiency as a result.

Similar issues and trends exist for Medicare-Medicaid "dual-eligible" beneficiaries, but the fragmentation of financing and benefits across Medicare and state programs has created even more coordination issues. As a result of the gaps in quality and coordination of care that result in preventable complications and avoidable costs, the goal of better-integrated care for dual-eligible beneficiaries has widespread support. Better coordinated services for these patients, encouraged by better-aligned Medicare and Medicaid financing, represents a critical opportunity for bending the curve of rising health care costs by improving care. Beginning this year, CMS is implementing a three-year, multi-state demonstration using new integrated payment models to support better care delivery at a lower cost for dual-eligible beneficiaries—either capitated Medicare-Medicaid managed care plans or state-managed reform initiatives with integrated financing. CMS has already approved five large-scale demonstrations, and many other states are pursuing implementation of similar demonstrations. To be sure, there are also concerns about cutting back or disruptions to care for these high-risk, vulnerable patients. However, in a three-year case-by-case demonstration, it is difficult to implement either the

state support (data systems, best practices, etc.) or the infrastructure for measuring performance to help ensure that quality and access improve.

Given this context, we are building on our previous Medicaid-related recommendations with further steps to reduce costs while providing needed care for vulnerable patients.

Create a Standard Program for Person-Focused Medicaid, Enabling States to Implement and Track Performance of Medicaid Reforms that Reduce Per-Beneficiary Cost Growth While Maintaining or Improving Quality of Care, and Enhance States' Share of Savings From These Reforms

Our proposal would move Medicaid away from operating on the basis of one-off waivers to a more standard and systematic process for states to implement Medicaid reforms that achieve reductions in per capita cost growth while maintaining or improving quality of care. This mechanism would support health care services provided by capitated Medicaid managed care plans, as well as reforms managed more directly by states that focus on particular components of care (e.g., primary care services, bundled or coordinated payments for high-risk beneficiaries or beneficiaries with particular behavioral health or chronic disease issues). Streamlining the current waiver review process, these Medicaid reforms would create an improved data infrastructure with standard processes and evaluation methods for states to implement and modify reforms that reduce per beneficiary costs while maintaining or improving quality of care. The reforms would also enable states to share in more savings given their leading role in investing in the success of these reforms.

- Rather than negotiating individualized waivers on a one-off basis with states, CMS would implement a long-term, system-wide strategy for "Person-Focused State Medicaid Plans" that would support, monitor, and evaluate the plans' impact. The Person-Focused Plans could rely on Medicaid managed care plans or on state-managed care reform approaches. States that develop such Person-Focused Plans that meet the minimum standards for participation would have an accelerated approval process, much more like the plan amendment process for the Children's Health Insurance Program (CHIP).

- The program infrastructure would start with base per capita and global spending projections. States that are able to reduce per capita and overall Medicaid spending growth significantly below expected benchmark trends would be able to keep a disproportionate share of the savings (and would also be accountable for a disproportionate share of cost overruns). For example, Oregon's current waiver anticipates a two-percentage point reduction in per capita medical costs by the end of the second year with significant financial penalties for the state if the per capita goals are not met. In our analysis, we considered models in which states would receive 50 percent of the federal savings.

- CMS would develop and support standard measures for Person-Focused State Medicaid Plans that could be applied consistently across states and that would complement performance measures used in Medicare and private insurance when appropriate. With data and evaluation support from this core CMS program, states would have to implement an ongoing evaluation capability to track the impact of the reforms on access to and quality of care in Medicaid. The measures should be person-focused and outcome-oriented, including access to care (e.g., standard source of primary care), use of preventive services and wellness, use of evidence-based care, outcomes for common chronic diseases, coordination of care measures for complex patients (e.g., readmission rates and medication reconciliation), and measures of patient and caregiver experience with care. Measures would also include overall rates of insurance coverage (Medicaid or private) in the state among lower-income populations.

- States could target initiatives to key patient populations that are priorities for achieving improvements in care and reductions in costs. This should include complex patients with high expected costs. CMS would develop specific benchmarks and evaluation support for high-risk/high-cost populations, and would prioritize efforts to help states adopt successful models and best practices. It should also include improving use of preventive services and reducing health risk factors for otherwise healthy populations, particularly children.

- While this reform structure is intended to bring a much more person-level and innovative approach to care in Medicaid, it could be implemented progressively over time based on state experiences and supporting infrastructure. States would have progressively greater authority to reform provider payments in Medicaid and benefit designs, potentially starting with regional pilots and "optional" Medicaid populations. Unlike current waivers, however, states would have a clearer set of long-term reform goals and more systematic support for achieving improvements in care and health. States that are able to implement more comprehensive evaluation mechanisms, and demonstrate improvements in key performance measures, would have greater opportunities to share in savings and risk in addition to more flexibility in designing and implementing Medicaid reforms. Over time, as experience and support accumulates, states would be expected to achieve greater savings in comparison to current Medicaid per capita cost trends.

- States would be encouraged to combine funding streams and support innovative, efficient strategies for care delivery for low-income uninsured populations, and for dual-eligible beneficiaries, as described below. States could also use these reforms to support statewide, multi-payer efforts that lead to measurable improvements in access to and quality of care.

Align Medicaid Reforms with Other Initiatives and Financial Support for Health Care for Lower-Income Individuals to Facilitate Care Continuity and Improve Efficiency

- States and CMS should facilitate the participation of Medicaid managed care plans in state insurance marketplaces to prevent shifts in and out of Medicaid eligibility that disrupt both coverage and how individuals receive their care. States and CMS should establish preferences for Medicaid plans for "optional" patient populations that offer similar or identical benefits to plans offered to low-income individuals on the marketplaces.

- Many lower-income individuals, including some particularly high-cost patients with physical and behavioral health needs, currently receive support services outside of Medicaid. These include both the health care safety net (such as local safety-net initiatives and programs for mental health and Federally Qualified Health Centers) and key non-health care services such as housing and social work assistance. These sources of care are likely to remain important after 2013. To help improve outcomes, CMS should facilitate state reforms that coordinate the delivery of services in these programs. This could be done by combining funding streams for the safety-net providers with greater accountability for care improvements for the populations they serve. Examples of local initiatives that are already taking steps like these include: Camden Coalition of Health Care Providers (a city-wide comprehensive care management program that includes social work, residential, and behavioral support, with integrated funding streams); Denver Health (an integrated system that provides safety-net care and broader population care in the Denver area, including services and funding streams for emergency care, mental health services, school clinics, and prison services); and the New York Institute for Family Health (which includes federally-supported community health centers coordinated with specialist/hospital care as well as social services support).

Expand and Make Permanent the CMS Capitated Financial Alignment Demonstration for Medicare-Medicaid Beneficiaries with a Strong and Systematic Ongoing Evaluation and Support Capacity

This proposal would implement a more systematic, long-term infrastructure to support coordinated care for dual-eligible beneficiaries. Such an infrastructure is not feasible in the short-term, case-by-case approach of the current demonstration program and is needed to be able to develop, assess, and expand the dual-eligible reform programs that work.

- CMS would transition the capitated model in the "Financial Alignment" initiative to a permanent Dual-Eligible Aligned Care Initiative, which would provide more certainty for state planning purposes and encourage states to invest with the federal government in the needed long-term operations and evaluation infrastructure for the program.
- A permanent program would be accompanied by a substantial evaluation and quality improvement infrastructure at CMS for the Aligned Care Initiative that: 1) provides timely access to Medicare data on dual-eligible beneficiaries to the states and their provider and plan partners; 2) produces much more meaningful measures of quality of care and costs for dual-eligible beneficiaries; and 3) shares evidence and best practices with states on effective steps for improving care for dual-eligible beneficiaries. Such an infrastructure is difficult to establish in a temporary demonstration but is an essential step to provide more support for better-coordinated care than exists today and to ensure that the state reforms are truly improving care.
- Combined shared savings would be calculated across both Medicare and Medicaid, and should be shared with states at least in proportion to state shares of overall dual-eligible costs. Calculating Medicare and Medicaid savings separately undermines incentives to coordinate care to achieve maximum system-wide savings, and are not necessary to achieve significant federal savings relative to current dual-eligible policies.
- The evaluation measures to be used in an ongoing basis in this initiative would be tailored to the dual-eligible population and should include measures of patient experience and care coordination, as well as increasingly comprehensive measures of other aspects of quality of care.
- State reforms that do not show both improvements in performance measures and overall cost trends would be phased out, with increasing incentives over time for states to switch to effective plans, as the experience and capacity of the initiative increases.

REFORMS FOR PRIVATE HEALTH INSURANCE MARKETS AND COVERAGE

Reforms in private insurance coverage and marketplaces for businesses and individuals are critical to lower costs and improved care. In addition to providing coverage for most Americans, these plans are implementing innovations such as wellness and care management programs and other steps toward more consumer engagement in health care and health improvement. As we have highlighted in previous reports, key reforms should include steps that promote such a person-level focus on better health without unnecessary costs. These

reforms include: reliable comparative cost and quality information to inform health plan choices; subsidies for coverage based on income and health need that are not open-ended, to share more savings from high-value choices; flexibility in the design of benefits and provider payments in the insurance plans to enable insurance plans to support high-value care; and steps to ensure that insurance markets are stable and work well for high-risk and vulnerable individuals.

The implementation of the ACA's insurance marketplaces beginning in 2014 provides an opportunity to help achieve these goals by improving access to coverage in non-group health insurance markets, promoting competition and efficiency in those markets, and thereby, driving improvements in health care delivery. The marketplaces will be supported by subsidies for health insurance coverage that are income-related, that enable beneficiaries to get the full savings of choosing a lower-cost plan, and that, after 2018, increase essentially with the growth of the economy. These key features of subsidy design are ones that our other proposals seek to bring to the rest of the health care system. However, the promise of effective reform in the individual and small-group market may only be realized if further critical further steps are taken during implementation. These include steps to assure flexibility for insurers to provide cost-effective benefits such as value-based insurance designs and network plans, additional steps to address adverse selection while promoting strong competition, and other measures that will hold down costs—all while demonstrating access to quality care.

Along with these reforms in insurance marketplaces for individuals and small businesses, analogous financing reforms are needed for employer-provided coverage. We have previously proposed reforms in the currently open-ended tax exclusion for employer-provided health insurance to achieve this goal. That tax expenditure has a cost of around $250 billion annually to federal and state governments. Moreover, it is not well targeted to those who need the most help with health care costs and it encourages less efficient care. We renew this proposal here, and also describe several other steps that would enable employers and private insurance plans to do more to lead efforts to improve quality in ways that lead to lower costs.

Limit the Exclusion of Employer-Provided Health Insurance Benefits from Income by Imposing a Cap that would Grow at the same Per Capita Rate as Federal Subsidies in Medicare and/or the Marketplaces

- In conjunction with providing better information on the quality of care in employer plans, the employer-provided health insurance subsidy should be capped. This could be accomplished over time by capping the exclusion at a high level initially, similar to the intent of the ACA provision in current law, and not index the cap until the subsidy value is closer to alignment with the subsidy in the insurance marketplaces. After that, the subsidy could increase at the rate of GDP growth, as the marketplace and Medicare subsidies would do under our other reform proposals. A somewhat higher average subsidy for employer coverage could help discourage shifts to the non-group marketplace (exchange), but concerns about such shifts can be addressed while still capping the exclusion. If this step is linked to broader tax reform that also reduces marginal tax rates, any additional costs in employee tax liability could be offset by the combination of lower tax rates and lower health care costs.

- At a minimum, retain the ACA provision on taxing high-premium insurance plans beginning in 2018. The current-law excise tax equals 40 percent of the total premium of a plan in excess of a threshold, which is set at the high level of $10,200 for individuals and $27,500 for families, and is indexed to the CPI after 2019. The additional cost of insurance premiums above the tax threshold encourages the selection of plans with premiums below the threshold.

Encourage and Support Employer Leadership in Driving Innovative Reforms in Health Care Coverage and Delivery

» Assure that Employment Retirement Income Security Act (ERISA) and other health plan regulations do not inhibit the use of value-based insurance designs, tiered benefit designs, and employees' ability to share in the savings from health care choices and changes in their behavior that reduce costs. This would facilitate employer efforts to engage employees in reducing overall health care costs.

» To promote transparency, make available standard measures of provider performance from Medicare and Medicaid that could be more easily combined with similar measures constructed by employers from their own data on health care costs and quality, as we describe below.

» To promote effective financing reform, facilitate adoption of payment reforms in Medicare and Medicaid that match value-based payment reforms adopted by private-sector payers.

Promote Competition that Lowers Costs while Providing Access to Valuable Services and that Creates Appropriate Incentives for States

» Implement regulations for insurance marketplaces that allow for actuarial equivalence in benefit design to promote innovation in value, such as tiered benefits with lower co-pays for less costly care choices, and networks of high-value providers and cost-effective treatment options, in conjunction with reporting on quality measures.

» Allow for value-based standards for coverage of medical treatments in meeting the minimum requirements for essential benefits for creditable coverage.

» Given the disparities in covered benefits across states, and the cost of enhancements in state-mandated benefits being borne by the federal government and not the states, offset state-specific subsidy growth that is attributable to increases in the impact of state-required benefits over time. For example, state regulations that expand required coverage of treatments from alternative medical providers, specialty services and products, etc., should not cause an increase in the value of federal subsidies in the state over time. One way to accomplish this goal would be to track the actuarial value of state-required benefits over time. These actuarial values are likely to vary considerably, and state-specific increases in these values should not cause an increase in the value of federal subsidies in the state.

Facilitate Stable Non-Group and Small-Group Health Insurance Markets in the Absence of a Strong Mandate by Minimizing the Risk of Adverse Selection and Shoring up the Safety Net

Reforms that encourage choices of less costly plans in insurance marketplaces require effective policies to assure that health plans compete on quality and value and are not rewarded for designing benefits to select healthy, low-cost enrollees. While we believe that the reforms we have proposed will achieve a needed emphasis on and balance between encouraging efficiency and providing access to quality care, further steps will help assure that adverse selection problems can be addressed or avoided.

» The current penalty for individuals who do not have "creditable" insurance coverage will encourage participation in insurance markets. However, the penalty is small relative to the cost of insurance, especially in the early years and especially if Congress or the Administration limit enforcement or slow its implementation. Consequently, other steps to reduce adverse selection will be important to encourage broad participation and keep insurance premiums affordable:

- Enhancing participation through effective broad-based outreach and enrollment support, particularly for those from lower socioeconomic groups and in low-income areas, and those facing language or other barriers to enrolling in an optimal plan. Default enroll individuals who are eligible for subsidies.
- Limiting open enrollment periods to one to two months per year.
- Imposing limits on individuals' ability to shift from a plan with relatively low actuarial value to a higher value plan (for example, allowing movement from a "bronze" to a "silver" plan in terms of actuarial value during open enrollment, but not a "bronze" to a "gold" plan).
- Relaxing the requirement for full community rating when consumers have not maintained continuous coverage, and including late enrollment penalties (as in Medicare Part B and Part D).
- Allowing temporary limits on coverage for pre-existing conditions for consumers who have not maintained continuous coverage.
    - Considering at least temporary extension of additional financial support for highest-risk individuals, for example through enhanced reinsurance payments.

» Monitoring for potential adverse selection problems will require consistent data and analytic capacity but does not require exhaustive data requirements on health plans.

- Data on enrollment and health status reported by health plans for calculating risk adjustment models can also be used to monitor trends in market participation and adverse selection. Aggregate data produced by insurers using standardized methods should be sufficient for this purpose, at least initially and in conjunction with audits. This information should be reported publicly and tracked at the market level to assess market sizes, stability, and risk status.
- The Department of Health and Human Services (HHS) should lead the development of a strategy and plan for reviewing and improving risk adjustment models across all of its major health care financing programs, including Medicare and Medicaid.

REFORMS FOR SYSTEM-WIDE EFFICIENCY

These proposals are designed to create a better environment for supporting quality, efficient health care delivery and high-value innovations in care. Because they support improvements in quality and efficiency in all of the major health care financing programs, they can enhance the system-wide impacts of our reform proposals for Medicare, Medicaid, and private insurance. The proposals build on our previous proposals to create a better infrastructure for health care delivery.

Simplify and Standardize Administrative Requirements

The time cost to clinicians of interacting with health plans has been estimated to be as high as $23 to 31 billion annually. Further, clinicians, health plans, and other participants in health care reform are currently subject to a wide range of diverse reporting requirements that add to costs and reduce the availability of actionable

information. Some steps have been taken recently to reduce these administrative costs through standardization. Further administrative simplification steps should include the following, all of which can be accomplished through existing standard-setting entities and public-private implementation initiatives:

- Implementation of an updated standardized claim form.
- Standard methods for quality reporting by providers and plans, including clinical, outcome, and patient-level measures—this would be an administrative benefit for providers that adopt value-based payment reforms across all of their payment systems and would lead to reduced reliance on cumbersome coding for specific types of providers.
- Standard methods for timely data sharing by plans with health care providers and patients who are involved in the financing reforms described in this report. Data sharing accomplished according to consistent standards would reduce the burden on providers and patients, and the IT vendors who serve them, for implementing the analytic tools needed to achieve greater improvements in care.
- Support for state investments to update their Medicaid information systems including standard quality measure reporting and access to CMS data for quality improvement.

Improve Cost and Quality Transparency

To support patients in making better decisions about their care—and driving the value-based insurance reforms that we have endorsed—patients need much better comparative information about the quality of their care and what they pay for it. This information should be provided where feasible at the point where patients are making decisions about care (e.g., quality and payment consequences of choosing different providers for an elective procedure or management of a non-emergent condition) and when they are making decisions about plan choice (e.g., which plan is the best value for patients with different characteristics and preferences). Of particular value to patients is personalized information on the out-of-pocket costs of their choices. Payers and purchasers also need information on total payments and quality for designing payment contracts more focused on value. Some important progress is occurring to make such information available, and the reforms we have described would significantly reinforce it (e.g., comparable information on bundled or patient-level payments for services, and relevant person-level performance measures, will facilitate the production of total and out-of-pocket payment information in conjunction with these reforms). The following steps would further promote useful transparency:

- Promoting the development and adoption of consistent methods across providers and payers for constructing quality measures and for plans to provide relevant out-of-pocket cost information, at least for a core set of important measures and conditions.
- Requiring plans, as a condition of participation in insurance marketplaces, to provide a common set of quality and utilization measures—not just at the plan level, but for the providers included in the plan. The provider-level measures could then be aggregated across private and public plans to achieve more comprehensive and reliable evidence on provider performance.
- Restricting gag clauses that prevent providers and plans from disclosing total and out-of-pocket payment information, where such price-related information is used for patient and purchaser decision tools.

While disclosure of price information might be expected to promote more effective price competition, there is some evidence that requiring more disclosures may undermine discounts offered by providers and plans that have substantial market power. Focusing on total payments for bundles of services and out-of-pocket payments actually incurred by patients—information

that determines the final flow of funds for health care spending—can help limit disruptions in service-specific rebates or other discounts that help hold down overall payments. However, as we note below, further steps are likely to be necessary to support effective price competition in markets where providers or insurers have substantial market power. Greater transparency about quality and practically meaningful prices is essential for improving decisions and will also enable more effective antitrust enforcement.

Promote Effective Antitrust Enforcement

Given the increasing complexity and diversity of individual patient needs, better support for care coordination can have important benefits for improving the efficiency and quality of care. To achieve better coordination, steps toward greater clinical integration are required, as is the financial support for such steps. This can be accomplished either through contracts and other business arrangements among health care providers, or through consolidation of providers. For example, some ACOs have been formed via contracts among physician groups and insurers; others have been formed via vertically- and horizontally-integrated health care delivery systems. While clinical integration may have important benefits, provider combination arrangements and consolidation can also increase provider market power. There is evidence that some of the recent consolidation in health care markets leads to higher prices that can offset the benefits of better integration of care.

In the context of recent payment and delivery reforms, the Department of Justice (DOJ) and the Federal Trade Commission (FTC) have reaffirmed their commitment to effective antitrust enforcement, which in practice generally occurs under a "rule of reason" standard. These entities have longstanding policies for analyzing the clinical and financial integration of providers, as well as mergers, reflected in guidelines that were recently updated in the context of ACOs. Appropriately, these analyses focus on the credibility of the clinical integration steps relative to the risk of market power. Merger analysis involves a higher level of antitrust scrutiny, as such contractual arrangements are more difficult to undo.

However, it is not clear that current policies are optimal as financing reforms and the availability of measures reflecting health care market performance continue to evolve. "Rule of reason" review should clearly reflect these recent developments. Consequently, we support further updates in the antitrust enforcement guidelines to place a substantially greater emphasis on the extent to which clinical integration is accompanied by financing reforms that move away from FFS payments and place providers at financial risk for higher costs. In addition, we support the production and improvement of increasingly robust performance measures that reflect both the quality of care and service- and patient-level cost outcomes. We have described these measures and payment reforms above. The complementary reforms in antitrust policy include the following steps, which also have implications for the enforcement of Stark and anti-kickback laws:

- For clinical integration activities above a reasonable market-share threshold of concern (and merger activities above a somewhat lower threshold), clarify that baseline and have an ongoing production of a timely, comparable set of quality and cost measures at the patient and population level as an important consideration for enforcement. In particular, a sufficient baseline of measures including patient-level cost and quality of care (e.g., one to two years for common conditions and procedures, and for overall per capita measures) should be produced using summary data from Medicare beneficiaries and a meaningful share of privately-insured individuals in the area that would be affected by the integration agreement. Such measures should also be expected in all existing high-concentration markets that are dominated by a small number of large, integrated systems.
- Clarify that enforcement review places weight on the extent to which payment contracts for providers move away from traditional financing based on

volume and price of particular services, and toward payments that increase when quality is higher and costs are lower, as a major factor in antitrust review. In these cases, provider revenues are more directly tied to efficiency and cost reduction, not higher prices or greater intensity. These types of contractual reforms should be considered indicators of reduced risk of anticompetitive behavior in provider combinations that involve joint contracting. For example, we support restricting the ability of hospitals and physician groups to negotiate physician reimbursement in their private insurance contracts unless the physicians and hospitals are engaged in contracts with significant risk-sharing for the overall costs of patient care.

» Update "safe harbor" guidelines to include ongoing performance measurement, to provide more direct evidence of anticompetitive behavior. Many clinical coordination arrangements or even mergers among high market-share organizations could be considered safer if the merged organizations commit to producing meaningful quality and cost measures over time, if the organizations implement contracts with payers that place substantial emphasis on reducing overall costs while improving quality, and if subsequent performance on these measures improves significantly. We view this as more meaningful evidence on the value of care than analysis that focuses on prices for specific services.

» Enhance the current antitrust enforcement practice of imposing higher standards and greater scrutiny for mergers relative to clinical/financial integration contracts. Financing and delivery reforms that do not require full integration of providers are easier to modify or undo than provider mergers if they do not work. They may also permit more flexibility in health care organization as further innovations occur in health care delivery.

» As part of this strategy for better evidence to guide antitrust scrutiny and policies, support the development and evaluation of standard and compelling quality and cost measures and a better understanding of developments in bundled and risk-based financing arrangements for guiding further antitrust policies. These alternative contracts and measures of quality and cost are increasingly common in payment reforms such as ACOs and bundled payments. Indeed, as we have noted, Medicare should produce these quality and cost measures as a routine matter, and private payers would also benefit from contributing aggregate data to such standard measures to describe and better understand the competitive dynamics of health care markets. Regional and state databases also have the potential to produce comparable longitudinal measures. Analyses of these improved data on market performance and the associated clinical, financial, and consolidation arrangements should be used to refine antitrust criteria regarding whether combinations of providers are likely to present anticompetitive effects that outweigh the clinical benefits and thus should be challenged. Indeed, such standards might even be used as a basis for conditional approval of certain mergers, so that there is a greater expectation that they might be modified or undone if quality and cost improvements do not occur.

» Stark and anti-kickback laws should include safe harbors for providers that demonstrate they are combining clinical integration with meaningful financing reforms to improve care, and that demonstrate progress on improving care and lowering costs. Full integration should not be a substantial requirement for exceptions to such rules if the providers are engaged in financing reform with joint risk-bearing accompanied by meaningful performance measures. Other barriers to clinical coordination for non-merging providers should also be addressed.

Address Outdated Licensing Barriers for More Effective and Efficient Care

Providers often face barriers when transitioning to more efficient models of care delivery because of outdated

regulations that no longer provide sufficient benefit to patients. Prime examples of such regulations are state scope of practice laws that prevent nurses, pharmacists, and other non-physician health professionals from delivering clinical services for which they are trained and capable. The results of such laws are higher prices and more limited access to care without improvements in quality. States should reform scope of practice laws to allow all health professionals to practice at the top of their licenses and capabilities. Another set of examples involves barriers to telemedicine services caused by state-specific licensing restrictions. Given the similarity of physician licensing requirements across states, such barriers could be removed by enabling licensed providers of telemedicine services to have licensing reciprocity. These regulatory reforms would be accompanied by increased regulatory attention to the quality of care actually provided using the performance measures that are becoming more widely available and that would be accelerated under our proposed reforms, rather than relying just on "structural" regulation that is not closely related to quality of care.

Encourage States to Develop More Efficient Medical Liability Systems

Although estimates differ regarding the magnitude of impact of medical liability reform on health care cost growth and quality, liability reform remains a critical issue to many health care stakeholders and could reinforce reforms in care delivery that increase value. Since most tort law and related regulations are under state jurisdiction, reforms to foster a more effective medical liability system will likely require state action. To encourage state liability reform, we recommend that the federal government provide states with technical assistance and grant funding to test innovative reform models, and to include such liability reforms in state-based reform initiatives. These state-level reforms should focus on well-supported models such as:

- "Safe harbor" or "rebuttable presumption" laws that establish legal protections for providers who achieve high quality and safety performance using valid measures.
- Reforms that modify the existing judicial process for resolving tort claims with lower-cost and more predictable alternatives. These include a "Patient Compensation System" that enables most claims to be settled through a standardized administrative process with predictable awards based on the adverse outcome involved, and Health Courts in which independent experts with clinical expertise would adjudicate liability claims.

Enable States to Implement Other System-Wide Reforms

Many states are taking steps to support broad-based, multi-payer initiatives to improve care and lower costs. These include supporting health information exchanges, providing "multi-payer" system-wide quality and cost information to the public, and leading broad-based efforts to improve care such as medical homes and prevention/ wellness initiatives. With the Supreme Court decision leading to more state flexibility in Medicaid coverage expansions and with the central role of states in implementing and guiding insurance marketplaces, states need more support in using their unique opportunities to lead broad-based health care reform efforts. At the same time, comparable performance measures are needed across states to provide better evidence on which system-wide reforms are most effective and to help states identify best practices and make improvements as they implement reforms.

Many of the reforms we have proposed above will support this goal. They include:

- A facilitated pathway for Medicare to join in state-based payment reforms intended to improve the value of care if the reform has a "critical mass" of participants in a state or region, including state employee/retiree plans, Medicaid plans, and private plans.

- Enhanced opportunities for states to share in savings in Medicaid and Medicare that are generated as a result of state-led reforms affecting beneficiaries in these programs.
- Enhanced infrastructure to support state-led reforms and demonstrate their impact on quality and cost trends, such as the greater availability of consistent performance measures on quality and cost from Medicare and the private sector.

IMPLICATIONS FOR SAVINGS

Our health care reform proposals create an increasingly direct and systematic focus on supporting better care for patients. The resulting changes in care permit lowering per capita expenditure growth without compromising quality and while supporting continued innovation. Critical to this effort is the implementation of a reform framework now that enables Congress and the Administration to shift their attention to overall quality of care and cost growth, without imposing major short-term changes in particular programs. Implemented as we describe it here, our framework will also lead to significant scored savings, especially in the longer term. The proposed reforms in federal subsidies, tax expenditures, and provider payment programs can also be "dialed up" or "dialed down" before or during implementation. Because we have focused on this framework for effectively bending the curve through improvements in care, we have not included a range of other proposals—for example, income-related premiums, eligibility changes, or provider payment reductions in Medicare or Medicaid—that can also achieve cost savings. Many of us also support different versions of these proposals for savings.

Table 4 provides a summary of estimated cost savings by program from our proposals. Our summary notes no net cost reductions in Medicare over the next ten years. Under current law, Medicare per capita costs are projected to grow less quickly than GDP per capita during this decade, in particular as a result of relatively slow cost growth continuing in the coming years (Medicare cost growth per capita is projected to accelerate past GDP growth in the second half of the decade). As noted above, we believe that sustaining this slower rate of growth is much less likely to be feasible without our proposed reforms to support better ways to deliver care. To facilitate the adoption of Medicare Comprehensive Care and a more effective system for beneficiary choice and engagement in care, we believe it is necessary to direct savings from our proposed reforms in Medicare benefit design, dual-eligible care, Medicare Advantage competition, and Medicare's traditional payment systems to shore up gaps in Medicare's current law policies. This includes implementing a replacement for the Medicare physician payment system that fits with our overall payment reform strategy and other transitional incentives and support for providers.

The estimated net savings in our reform plan come from its other elements. The effective implementation of Medicaid reforms like those in Oregon and California, due to both a clearer infrastructure to support better reforms and new opportunities for state savings, suggests that we can expect federal savings of around $100 to 120 billion over ten years. State savings would be larger. Under our reforms, Medicaid spending per beneficiary would still be expected to grow faster than GDP, and performance improvements would have to be met. The savings from transitioning to a cap on the tax exclusion for employer-subsidized insurance are a modest fraction of the current tax expenditure on the exclusion and could be achieved with transitioning to a

cap at a somewhat lower level than used in the current law excise tax starting in 2018, but not much lower. That is, the vast majority of employer plans would have many years to adapt to the cap, but would still have a clear indication of the need to transition to a greater emphasis on efficient person-level care. This tax reform could be implemented as part of a tax reform package that includes offsetting savings for affected workers elsewhere, for example by modest reductions in income tax rates. Our proposal to tie exchange subsidies to GDP growth on a per capita basis also represents incremental additional savings beyond current-law projections on per capita subsidies over the next decade.

Altogether, these proposals amount to close to $300 billion in net savings over the next decade. The ten-year savings could be scaled up for additional savings (e.g., tighter limits than GDP growth in any or all four of the major health care entitlement programs) or by accompanying these reforms with other savings proposals. The ten-year savings could also be scaled down through higher per capita cost growth benchmarks. In addition, we believe our system-wide reforms—administrative efficiencies, antitrust policy, updating regulations affecting medical practice, reforming medical liability, and giving states new incentives to adopt these and other system-wide reforms—should produce significant additional savings.

NEXT STEPS

Our proposals can and should be considered as part of any policy reform debate about health care. Whether or not a "grand bargain" on deficit reduction and entitlement reform comes together in the near term, the general principles behind our proposals are likely to remain relevant in the future. Therefore, we think the time to act on these proposals is now. Health care is moving in a more personalized direction, where integration of more diverse science, health care providers, treatments, and opportunities to prevent diseases and complications will be a theme in achieving better care for patients for many years to come. Our proposals will support this needed innovation in medical technology and its use to benefit individual patients on the one hand, while bending the curve of rising health care costs on the other. This is the best path to achieve improvements in health as well as affordable costs: it is time to put a sharp and direct focus on achieving both better health and cost savings. Enacting such legislation now will create more certainty and support for providers and plans to make needed investments in higher-value care for the future and will permit the maximum opportunities for health improvements and savings.

In the meantime, in the absence of legislation on federal health care entitlement reform, it is possible to use this framework to make progress. All of our proposals build on important trends and pilots already taking place throughout our health care system. For example, CMS could develop a consistent set of outcome-oriented performance measures and resource use measures, create better data systems for providers to access the claims data they need to improve care, and implement a clear, timely, and comprehensive strategy across programs. CMS can also do more to develop an infrastructure to support state waivers that enable meaningful shared savings for steps that achieve better care and lower costs in Medicaid. In addition, legislation in more specific areas of health care, such as Medicare physician payment reform, can and should reflect our framework. Any Medicare physician payment reform or other incremental steps in Medicare should include a

systematic path for supporting measurably better health care and lower costs. However, while helpful, these steps are no substitute for more comprehensive reform legislation.

We have also outlined many ways in which states can build on state reform progress. Private employers can also do more to support multi-payer financing reforms including contributing consistent data to more comprehensive and effective ways to measure quality and continuing to innovate in reforms in benefit design to promote higher-value care.

Along with other organizations, we expect to monitor and encourage progress toward these reform goals in the future. With so much at stake, both for our health and our nation's fiscal and economic outlook, reforming health care to improve value and to bend the curve needs to happen now.

TABLE 1: OPPORTUNITIES FOR IMPROVING CARE AND HEALTH—ILLUSTRATIONS FROM THE NATIONAL STRATEGY FOR QUALITY IMPROVEMENT IN HEATH CARE

National Quality Strategy Priority[1]	Measure	Current Rate
Making Care Safer by Reducing the Harm Caused in the Delivery of Care	**Incidence of measurable hospital-acquired conditions**	**145 Hospital Acquired Condition (HAC) per 1,000 admissions**
Ensuring that each person and family is engaged in their care	Adults who needed care right away for an illness, injury, or condition in the last 12 months who sometimes or never got care as soon as wanted	**14.1%**
	People with a usual source of care whose health care providers sometimes or never discuss decisions with them	**15.9%**
Promoting Effective Communication and Coordination of Care	All-payer 30-day readmission rate	**14.4%** based on 32.9 million admissions
Promoting the most effective prevention & treatment practices for the leading causes of mortality, starting with cardiovascular disease	People who have hypertension who have adequately controlled blood pressure	**46%**
	People with high cholesterol who have adequately managed hyperlipidemia	**33%**
	People trying to quit smoking who get help	**23%**
Working in Communities to Promote Best Practices for Healthy Living	Percentage of adults who reported symptoms of a major depressive episode (MDE) in the last 12 months who received treatment for depression in the last 12 months	**68.3%**
	Proportion of adults who are obese	**35.7%**
Making Quality of Care More Affordable by Developing and Spreading New Health Care Delivery Models	Percentage of people under 65 with out-of-pocket medical and premium expenses greater than 10% of income	**18.5%**
	Annual all payer health care spending per person	**$8,402**

[1] U.S. Department of Health and Human Services. *2012 Annual Progress Report to Congress: National Strategy for Quality Improvement in Health Care*. Revised. Washington: Agency for Health Care Research and Quality, August 2012. http://www.ahrq.gov/workingforquality/nqs/nqs2012annlrpt.pdf

TABLE 2: HEALTH SPENDING PROJECTIONS UNDER CURRENT LAW

		Projected Spending		Projected Annual Growth Rates	
		Total (in billions)	Per Capita	Per Capita	Per Capita
Program	**Policy Description**	**Real Spending**	**Real Spending**	**Real Spending**	**Cost Growth in Excess of GDP**
Medicare	Beginning in 2015, IPAB is required to make recommendations to reduce Medicare spending if per capita Medicare spending exceeds the specified target growth rate. From 2015 to 2017, the target growth rate is based on CPI. Beginning in 2018, the target growth rate is the increase in per capita GDP+1%.	**2014:** $585 **2023:** $854 **Total, 2014-2023:** $6,982	**2014:** $11,037 **2023:** $12,552	**2014-2018:** 0.01% **2019-2023:** 1.9% **2014-2023:** 1.0%	**2014-2018:** -2.2% **2019-2023:** 0.8% **2014-2023:** -0.7%
Medicaid	No spending growth target under current law.	**2014:** $287 **2023:** $453 **Total, 2013-2022:** $3,783	**2014:** $5,038 **2023:** $6,766	**2014-2023:** 3.4%	**2014-2023:** 1.6%
Employer-Provided Insurance Tax Subsidy	Open-ended tax exclusion under current law. In 2018, 40% excise tax on plans with premiums over $10,200 for individuals and $27,500 for families, indexed by CPI+1% in 2019 and CPI beginning in 2020.	**2012:** $280 **2017:** $330 **Total, 2012-2017:** $1,815	**2013-2022:** $2,328	**2014-2017:** 3.6%	**2014-2017:** 1.2%
Exchange Subsidies	After 2018, the required percentage of income paid toward premiums will be adjusted if the growth in premium and cost-sharing subsidies exceeds 0.504% of GDP.	**2014:** $27 **2023:** $134 **Total, 2014-2023:** $1,402	**2014:** $5,326 **2023:** $6,564	**2015-2023:** 2.4%	**2015-2023:** 0.9%

Note: Estimates based on analysis of Congressional Budget Office and Treasury data.

TABLE 3: SUMMARY OF PROPOSALS

Reforms in Medicare:

- Transition to "Medicare Comprehensive Care"
- Reform Medicare benefits to support more comprehensive beneficiary care and lower costs
- Reform Medicare Advantage to promote high value health plan competition

Reforms in Medicaid and Care for Vulnerable Populations:

- Create a standard program for person-focused Medicaid, enabling states to implement and track performance of Medicaid reforms that reduce per capita beneficiary cost growth while maintaining or improving quality of care, and enhance states' share of the savings of these reforms
- Align Medicaid reforms with other initiatives and financial support for health care for lower-income individuals to facilitate care continuity and improve efficiency
- Expand and make permanent the CMS Capitated Financial Alignment
- Demonstration for Medicare-Medicaid Enrollees with a strong and systematic ongoing evaluation and support capacity

Reforms in Private Health Insurance Markets and Coverage:

- Limit the exclusion of employer-provided health insurance benefits from income by imposing a cap that would grow at the same per capita rate as federal subsidies in Medicare and/or the Marketplaces
- Encourage and support employer leadership in driving innovative reforms in health care coverage and delivery
- Promote competition that lowers costs while providing access to valuable services that creates appropriate incentives for states
- Facilitate stable non-group and small-group health insurance markets in the absence of a strong mandate by minimizing the risk of adverse selection and shoring up the safety net
- Address outdated licensing barriers for more effective and efficient care

Reforms for System-Wide Efficiency:

- Simplify and standardize administrative requirements
- Improve cost and quality transparency
- Promote effective antitrust enforcement
- Encourage states to develop more efficient medical liability systems
- Enable states to implement system wide reforms

TABLE 4: COST SAVINGS FROM BENDING THE CURVE III PROPOSALS

Program	10-Year Savings (in billions)	Notes
Medicare		
Transition to Medicare Comprehensive Care with Per-Capita Growth of GDP+0	$0 (2014-2018) $120 billion (2019-2023)*	Over the next decade, Medicare spending growth is projected to average below GDP+0 per capita. To ensure that this growth rate is sustained throughout the decade while improving quality, the savings from our Medicare reform proposals (including physician payment reform and other reforms in traditional Medicare payments) would be directed back into Medicare to support the transition to Medicare Comprehensive Care. Limiting per capita spending growth to GDP+0 in MCC programs and in Medicare's traditional fee-for-service payment systems in the second half of the 10-year period (e.g., through IPAB or across-the-board reductions in payment updates) provides an additional estimated $120 billion in savings that would be used for this purpose, in addition to savings from the Medicare reforms listed below.
Medicare Benefit and Medigap Reforms	$60 billion*	Reform Medicare benefits with a limit on out-of-pocket payments, a single deductible, and more rational co-pays, as in MedPAC proposals. Eliminate "first dollar" Medigap coverage; Medigap plans will have actuarially-equivalent co-pays of at least 10%. MCC providers could offer lower co-pays and premiums to beneficiaries. These reforms would reduce average beneficiary out-of-pocket payments, provide better protection against high costs, and lead to additional beneficiary savings when beneficiaries use high-value providers.
Medicare Savings from Dual-Eligible Aligned Care Reforms	$20 billion*	Medicare savings associated with the Dual-Eligible Aligned Care Program.
High-Value Health Plan Competition in Medicare Advantage	$20 billion*	Limit MA plan subsidy growth to GDP+0 per capita. Plans should receive the entire difference between their bid and the benchmark if they return the difference to beneficiaries in the form of lower premiums and half of the difference if the difference is instead returned in the form of additional benefits.

* Savings are from the specific proposals and are directed to implementing MCC and other reforms that improve quality and sustain GDP+0 per capita spending growth over the coming decade. This includes reforming physician payment to replace the SGR with our proposed reforms.

Medicaid		
Person-Focused Medicaid Reforms, with standard process and infrastructure for Medicaid reforms that reduce per beneficiary cost growth while maintaining or improving quality of care	$100 billion	Reforms expected to reduce federal spending growth over the next decade by an average of 0.75% of GDP per capita relative to current law. This would involve achieving greater total Medicaid savings compared to current law (e.g., 1.5% per capita slower growth) with a larger share of the overall savings passed on to the states.
Dual-Eligible Aligned Care Program	$20 billion	Expand the CMS Capitated Financial Alignment Demonstration to a permanent Dual-Eligible Aligned Care Initiative with supporting infrastructure and faster/clearer implementation pathway. A model for a payment structure that ensures savings would be specified and states would share in the savings.

TABLE 4: COST SAVINGS FROM BENDING THE CURVE III PROPOSALS

Program	10-Year Savings (in billions)	Notes
Insurance Markets		
Cap the employer-sponsored insurance tax exclusion and limit growth to spending target	$120 billion	Phase in a cap on the tax exclusion somewhat below the level of the current excise tax (but significantly above marketplace subsidy caps), and constrain spending growth to GDP+0 per capita once a meaningful cap is established.
Encourage and support employer leadership in implementing innovative reforms in health care coverage and delivery, and encourage flexibility in benefit design		
Limit marketplace subsidy growth to GDP+0 per capita plus further reforms affecting benefit design, adverse selection, and other insurance market issues	$50 billion	Limited impact because current law constrains subsidies if total marketplace subsidy spending exceeds 0.504% of GDP after 2018. Specific mechanisms will be specified once the marketplaces and product offerings are known.
System-wide Reforms		
Simplify and Standardize Administrative Requirements	$20-$50 billion	
Improve Cost and Quality Transparency		
Promote Effective Antitrust Enforcement		
Address outdated licensing barriers		
Encourage States to Develop More Efficient Medical Liability Systems	$20 billion	
Enable States to Implement System-wide Reforms	$20 billion	Opportunity for states to share in Federal savings from system-wide reforms provides incentives for states to implement these reforms.

APPENDIX

APPENDIX TABLE 1: PREVIOUS "BENDING THE CURVE" REPORTS AND PROGRESS TOWARD BTC GOALS

BTC I (2009)	BTC II (2010)	BTC III (2013)
Building Necessary Foundation for Cost-Containment and Value-Based Care		
• Ensure investments in health IT are effective (link "meaningful use" bonuses to better results, create interoperability and provider communication standards, fund technical support program) **(Beacon Communities through the HHS Office of the National Coordinator for Health IT. CMS Medicare and Medicaid EHR Incentive Programs to measure meaningful use- must meet 20 of 25 meaningful use objectives)** • Make best use of Comparative Effectiveness Research (create entity to allocate CER funding, emphasize areas of medical uncertainty, protect providers and insurers from liability) **(AHRQ's Effective Health Care Program funds research efforts to produce effectiveness and comparative effectiveness research. ARRA created the Federal Coordinating Council for Comparative Effectiveness)** • Improve Health Care Workforce (amend state scope of practice laws, align Medicare payments to support allied health professionals, reform graduate medical education payments to promote teaching of high-value care practices) **(NCSL reports that as of October 2012, 349 bills have been adopted or enacted into law in various state legislatures related to changing scopes of practice. ONC Workforce Development Program to train workforce of skilled health IT professionals. The Graduate Medical Education Reform Act was introduced in May 2012 and would link graduate medical education funding to performance goals)**	• Build comparable data collection, aggregation, analytics, and reporting capabilities to more rapidly develop consistent evidence of the impact of reforms on cost and quality (build timely and consistent data feeds, adopt standardized performance measure) **(some common performance measures through ACO programs and other demos)**	• Accelerate comparable data collection, aggregation, analytics, and reporting capabilities and the use of consistent outcomes-based performance measures • Simplify administrative requirements (implementation of an updated standardized claim form, support for state investments to update Medicaid information systems, standards for quality reporting and timely data sharing) • Address outdated licensing barriers for more effective and efficient care • Encourage states to develop more efficient medical liability systems • Improve cost and quality transparency • Promote effective antitrust enforcement • Enable states to implement system-wide reforms

Key: Blue text indicates progress since the publication of BTC I and BTC II.

APPENDIX TABLE 1: PREVIOUS "BENDING THE CURVE" REPORTS AND PROGRESS TOWARD BTC GOALS

BTC I (2009)	BTC II (2010)	BTC III (2013)
Reforming Provider Payment Systems to Create Accountability for Lower-Cost, High Quality Cost		
• Adjust Medicare & Medicaid FFS (broaden bundled payments, expand the use of P4P, increase payment rates for primary care, provider additional payments during transition to PCMH, ensure Medicare payments support use of allied health professionals, reduce payments for care of low value relative to cost, increase spending on programs to reduce waste, fraud, and abuse, enable Medicare Prescription Drug Plans to share in overall savings, establish regulatory pathway for follow-on biologics) **(ACA established CMMI to test new payment approaches. Nursing Home VBP Demo, Hospital VBP Program, Medicare Home Health P4P Demo, the Biologics Price Competition and Innovation Act, part of the ACA, created an FDA approval pathway for "biosimilars")** • Build new payment systems for provider accountability (pilot ACOs, pilot "enhanced episode-based payment" systems and other promising payment systems, incorporate other bonuses into transition to accountable payment systems) **(CMS currently funds 153 ACOs through the PGP Transition Demo, Pioneer, and MSSP programs)** • Apply pressure to "Non-Accountable" Medicare payments (establish "virtual ACO" incentives, freeze market based payment updates for two years) • Improve payment/Coverage Flexibility and Rapid Learning to Achieve Lower Costs and Better Quality (expand and streamline CMS's piloting authority and resources, support public-private regional collaborative, empower an entity to improve the value and ensure the long-term sustainability of Medicare and Medicaid, reform medical liability, reform anti-trust laws and create processes for expedited waivers from anti-gainsharing and Stark laws)	• Speed payment reforms away from traditional volume based payment systems to align with quality and efficiency (design Medicare payment reform pilots—ACOs, bundled payments, coordinate CMMI and other pilot initiatives to promote collaboration between private and state payers as well as across federal initiatives) **(Implementation of Medicare Shared Savings Program and ACO Pioneer Pilot and a range of other CMMI payment reform pilots. Pioneer and Advanced Primary Care Medical Home pilots reinforce outcomes-based contracts with private payers)** • Strengthen & clarify authority of the Independent Payment Advisory Board (IPAB) **(effectiveness remains TBD)**	• Transition Medicare FFS to Medicare Comprehensive Care (aligned value-based payment systems for Medicare ACOs, medical home, episode-based treatments; globally capitated, comprehensive payment) • Increase states' ability to share in savings from Medicaid reforms • Medicaid reforms should be aligned with other options and financial support for lower-income individuals, to facilitate care continuity and improve efficiency • Expand and make permanent the CMS Capitated Financial Alignment Demonstration for Medicare-Medicaid Enrollees with a stronger and systematic ongoing evaluation capacity

Key: Blue text indicates progress since the publication of BTC I and BTC II.

APPENDIX TABLE 1: PREVIOUS "BENDING THE CURVE" REPORTS AND PROGRESS TOWARD BTC GOALS

BTC I (2009)	BTC II (2010)	BTC III (2013)
Improving Health Insurance Markets		
• Restructure non-group and small-group markets around exchange model that promotes competition on cost reduction and quality improvement (focus insurer competition on cost and quality, establish health insurance exchanges) **(ACA provision for establishing state or federal based exchanges)** • Reduce inefficient subsidies for employer-provided health insurance (cap existing income tax exclusion and adjust cap based on plan demographics and location) **(ACA provision to tax high cost plans starting in 2018)** • Promote competitive bidding in Medicare Advantage (set local benchmarks, establish significant quality bonus, consider transition to include Medicare FFS)	• Implement health insurance exchanges and other insurance reforms that rewards consumers with substantial savings when they choose plans that offer higher quality care at lower premiums • Set clear process for promoting vigorous competition among plans in the exchange **(preliminary regulations related to exchange, but much remain TBD)** • Develop viable alternatives to avoid adverse selection • Provide comparative monitoring and evaluation of insurance exchanges across states based on performance related to minimum functions required under ACA • Provide clarifications or loosen restrictions around ACA reforms which may impede health plans from adopting value-based designs **(Further VBID adoption among employers, private plans)** • Maintain, at minimum, current provision on taxing high-premium insurance plans (enact legislation to implement tax earlier—phasing in 2014 instead of 2018) **(ACA provision to tax high cost plans starting in 2018)**	• Reform Medicare Advantage for high value health plan competition in Medicare • Encourage flexibility in benefit design to promote competition that lowers costs while providing access to valuable services • Facilitate effective health insurance markets in the absence of a strong mandate with a particular emphasis on minimizing the risk of adverse selection and shoring up the health care safety net • Limit the exclusion of employer-provided health insurance benefits from income by imposing a cap on the exclusion. After a meaningful cap is established, it would grow at the same per capita rate as federal subsidies in Medicare and/or the exchange
Supporting Better Individual Choices		
• Reform Medicare benefit design to promote value & beneficiary savings (restructure Medicare Part A & B, establish tiered co-pays, reform Medicare supplemental plans, enhance and publicize provider quality & cost information, increase flexibility to alter benefits, assure that these steps lower beneficiary spending on health care) • Promote prevention and wellness to reduce costs (target obesity reduction, allow premium rebates for measureable health and risk factor improvements, establish public health outcome-based accountability) **(some adoption by employers, private plans)** • Support patient preferences for palliative care (provide opportunity for Medicare beneficiaries to file & update advanced directives, create liability safe harbor for providers)	• Reform coverage so that most Americans can save $ and obtain other meaningful benefits when they make decisions that improve health and reduce costs • Reform Medicare FFS benefit design and implement a competitive plan choice that is consistent with recommendations on plan choice to promote beneficiary savings from choosing higher-value care • Develop & expand demand-side wellness incentives including premium rebate to encourage all beneficiaries to undertake measurable health & risk-factor improvements	• Reform Medicare benefits to support more comprehensive care and lower costs • Recommend an out of pocket (OOP) maximum for Medicare beneficiaries accompanied by better mechanisms for incoming Medicare beneficiaries about their OOP costs (not counting Medigap) for different options for receiving care

Key: Blue text indicates progress since the publication of BTC I and BTC II.

APPENDIX TABLE 2: ILLUSTRATION OF PERFORMANCE MEASUREMENT PROGRESSION

Performance Measure Categories	Examples in Widespread Use	Examples in Limited Use*	Examples—in Development—Feasible through Supporting Outcome-Based Reforms
Preventative Health			
Colorectal Cancer Prevention	Colorectal Cancer Screening (Claims)	Quality of colonoscopy	
Cardiac Disease Prevention	BMI-Screening and Follow-Up (Clinically-Enriched)	10-Year Cardiac Disease Risk Factor Screening (Clinically-Enriched)	Use of Personalized Risk Score and Improvements in Risk Score (Clinically-Enriched plus Patient-Reported data)
Chronic Disease Care			
Diabetes Care	Preventable Hospitalization Rates (Claims); Hemoglobin A1c Control, LDL Control, Blood Pressure Control (Clinically-Enriched)	Major Clinical Complication Rates (Clinically-Enriched)	More comprehensive outcome measures including functional status
Ischemic Vascular Disease Care	Preventable Hospitalization Rates (Claims); LDL Control (Clinically-Enriched)	Functional Capability (Patient-Reported)	Coordination of Care between Primary Care, Cardiology, and Surgeons; Patient Experience with Treatment Process; More Comprehensive Functional Outcome Measures
Heart Failure Care	Preventable Hospitalization Rates; LDL Control (Clinically-Enriched)	Functional Capability (Patient-Reported)	Coordination of Care between Primary Care, Cardiology, and Surgeons; Patient Experience with Treatment Process; More Comprehensive Functional Outcome Measures
Cancer Care	Pain Intensity Quantified; Plan of Care for Pain; Radiation Dose Limits to Normal Tissues; Cancer Stage Documented	Patient Functional Status (e.g., pain, nutrition status) (Clinically-Enriched plus Patient-Reported data)	Measures of Cancer Progression using Biomarkers (Clinically-Enriched); Enhanced Patient Functional Status Measures (Patient-Reported)
Major Procedures and Treatments			
Joint Replacement for Osteoarthritis of Hip or Knee	Utilization Rate (Claims)	Post-Operation Complication Rates (Clinically-Enriched); Functional Status After Surgery (Patient-Reported)	Patient Experience with Operative Procedure (Patient-Reported)
Complex and Major Illnesses	Preventable Admissions and Readmissions (claims); Pressure Ulcers and Other Clinical Complications (Clinically-Enriched)	Patient/Caregiver Surveys of Care Preferences, Whether Preferences are being met by Care Teams (Patient-Reported)	Patient Functional Status and Quality of Life (Patient- and Caregiver-Reported)
Care Coordination and Safety	All-cause Readmission, Inpatient Admission Rate, ED visit rate (Claims); Screening for Falls Risk (Clinically-Enriched)	Condition-specific Readmission and Preventable Admission Measures by Condition (e.g., Ischemic Vascular Disease, Cancer) (Clinically-enriched); Patient Experience of Gaps/Questions in Care (Patient-Reported)	Enhanced Patient Experience Measures (Patient-Reported)
Patient and Caregiver Experience with Care Systems	Availability of Information about Plan, Overall and Categorical Ratings of Plan (Patient-Reported); Timely Care, Appointments and Information from Providers (Patient-Reported)	Overall and Categorical Ratings of Health Care Providers and Provider Networks like ACOs (Patient-Reported from surveys)	Enhanced ratings of more aspects of Health Care Providers and Provider Networks (Routine Patient-Reported data)
Resource Use	General Measures of List Prices (private) and Regulated Prices (Medicare) for Specific Procedures and Services (Claims or Price Reports)	Out-of-Pocket and Total Payments for Types of Services and Clinical Problems (Claims plus Clinically-Enriched data)	Personalized Out-of-Pocket and Total Payments made available to Individual Patients (Claims plus Clinically-Enriched data); Total Cost/Resource Use Measures for Conditions and Procedures (Claims plus Clinically-Enriched data)

* Used in pilot programs, regional initiatives, and/or some private plan and employer reforms

GLOSSARY

Accountable Care Organization (ACO) is a health organization in which provider payment is tied to quality metrics and reduction in overall cost of an assigned population. The ACO model seeks to improve beneficiary outcomes and promote value while slowing the growth in overall costs for a population of patients. It brings together coordinated networks of providers with shared responsibility to provide high quality care to their patients.

Adverse Selection occurs when sick individuals purchase health insurance in greater proportions than healthy individuals, thus raising the cost of health insurance premiums for everyone in a risk pool.

Affordable Care Act (ACA) is the health care law passed in 2010 that sought to significantly reduce the number of uninsured and underinsured by providing access to affordable health care coverage through Medicaid and health insurance marketplaces. The ACA also implemented reforms for providers, payers, and hospitals to increase the quality of care provided to patients and reduce the cost of health care over the long-term. In National Federation of Independent Business *(NFIB) v. Sebelius*, the Supreme Court determined that the Medicaid expansion would become a state choice rather than being required by the federal government.

Anti-kickback Statute prohibits providers from accepting or soliciting an item of value for the purpose of inducing or rewarding another party for referral of services paid for by a federal health care program. The statute was established in 1972 to protect patients and federal health care programs from fraud and abuse.

Antitrust Laws are designed to regulate corporations and encourage competition so that corporations do not become too large and set prices in the marketplace.

Bundled payment is a payment system in which multiple providers receive a single shared payment for a set of services, typically an episode of care (for example, a surgical procedure or the management of a chronic condition or conditions).

Center for Medicare and Medicaid Innovation (CMMI) is a branch of the Centers for Medicare and Medicaid Services that focuses on testing payment and delivery system models that provide promise for maintaining and improving the quality of care in all of the CMS programs (e.g., Medicare, Medicaid, CHIP).

Centers for Medicare and Medicaid Services (CMS) is a federal agency within the U.S. Department of Health and Human Services that administers the Medicare program and works with states to administer Medicaid and the Children's Health Insurance Program (CHIP).

Capitated Payment pays a physician or group of physicians a set amount for each enrolled person assigned to them, rather than paying physicians for a service provided. Physicians are expected to assume a certain level of risk under a capitated payment system.

Children's Health Insurance Program (CHIP) is a federal-state program that provides health care coverage for uninsured low-income children who are not eligible for Medicaid because their family incomes are too high. States are given flexibility in designing the administration of their CHIP programs—either through Medicaid, a separate program, or a combination of both. The federal government provides matching CHIP funding to states but federal CHIP funds are capped.

Coordinated Care Organizations (CCO) is a network of all health care providers who work together to provide services to individuals receiving health care coverage as described in the Oregon Medicaid plan and related state reform initiatives. CCOs coordinates the different types of services that patients would typically receive, such as physical, behavioral, and sometimes dental, and places the focus of the system on patient-centered care.

Congressional Budget Office (CBO) produces independent analyses of budget and economic issues related to the budget process, as well as cost estimates for Congressional legislation.

Consumer Price Index (CPI) is a measure of the price level of all goods and services paid for by households. It is widely used as a measure of inflation in the economy.

Dual Eligible Aligned Care is a CMS project that seeks to better align care for dual-eligible beneficiaries of Medicare and Medicaid through state demonstrations. CMS has proposed that states use either a fee-for-service model or a capitated model, and the state programs will be assessed on whether they improved quality and reduced costs.

Dual Eligible Beneficiaries are low-income Medicare beneficiaries who also qualify for Medicaid. Medicare typically pays for some aspects of their care, while Medicaid covers many services such as long-term care that are not covered by Medicare. Dual eligible beneficiaries typically have significant medical needs and a higher per capita cost compared to other beneficiaries.

Employment Retirement Income Security Act is a federal law that sets minimum standards for most voluntarily established pension and health plans in order to protect beneficiaries from the loss of benefits that are provided through a workplace.

Episode-Based Payment is a single payment for the services in an episode of care. The episode payment may be "bundled" for multiple providers, as described above (see Bundled Payment).

Exchange Subsidies Under the ACA, households that are below 400 percent but above 133 percent of the federal poverty line who have purchased health insurance in the exchanges are eligible to receive federal subsidies. The subsidies cover the premium amount above what these households are limited by the ACA to contribute to their health insurance premiums.

Excise Tax on High Premium Insurance Plans, also known as the Cadillac tax, is a 40 percent excise tax that will be applied to the value of health insurance benefits exceeding a certain threshold ($10,200 for individual coverage and $27,500 for family coverage). The excise tax takes effect in 2018 and is designed to discourage individuals and families from buying unusually high-cost insurance plans.

Federally Qualified Health Centers (FQHCs) are safety net health care providers that provide services regardless of the ability to pay and that are primarily funded by the federal government. FQHCs, such as community health centers and public housing centers, primarily provide primary care services in urban and rural communities.

Fee-For-Service (FFS) is a payment model where services are unbundled and paid for independently, thus making payments dependent on the quantity of care rather than the quality. FFS has been the traditional health care payment model for both federal health programs and private health insurance plans.

Gag clause is a provision in a contract between a health care provider or manufacturer and a health care payer (like a health plan) that prohibits disclosure of negotiated price information.

Health Insurance Marketplace (Exchange) provides a structured marketplace in which individuals would be able to purchase insurance from their choice of participating issuers. As part of the ACA, states can either be a state-based exchange, state partnership exchange, or federally-facilitated exchange. The responsibilities of both state and federal government differ in each scenario.

Independent Payment Advisory Board (IPAB) is a government agency established by the ACA that is tasked with achieving specified savings in Medicare without affecting coverage or quality. Beginning in 2015, IPAB is required to make recommendations to reduce Medicare spending if per capita Medicare spending exceeds the specified target growth rate as set by CMS. From 2015 to 2017, the target growth rate is based on CPI. Beginning in 2018, the target growth rate is the increase in GDP per capita plus one percentage point.

Medicaid is a joint federal-state program that provides health and long-term care coverage to low-income Americans. Each state designs its own Medicaid program within federal guidelines. States generally operate their major Medicaid coverage programs according to "Section 1115 waivers" (see below).

Medicaid Managed Care Plan is a managed care plan that provides coverage for Medicaid beneficiaries.

Medicare is a federal program that provides health insurance coverage to Americans over the age of 65 and younger individuals with permanent disabilities.

Medicare Advantage (MA) is a federal program through which private health insurance plans provide Medicare benefits to beneficiaries (Part C of Medicare).

Medicare Comprehensive Care (MCC) is a new program proposed by this "Patient-Centered Health Care Reform: A Framework for Improving Care and Slowing Health Care Cost Growth" report that consists of Medicare payments that are aligned with care improvements and lower costs. Providers in MCC organizations opt to receive a globally capitated, comprehensive payment for their defined population of patients and must meet a set of quality and outcome performance measures for full payment. Providers who are participating in accountable care organizations today or in the future could move into this program. Providers in MCC can also opt to receive case- or episode-based payments that also require achieving quality standards to receive full payment.

Medicare Part D is a federal program that provides subsidized prescription drug coverage for Medicare beneficiaries through competing private plans. The program was enacted as part of the Medicare Modernization Act of 2003 and went into effect in January 2006.

Medicare Payment Advisory Commission (MedPAC) is an independent Congressional agency that advises Congress on issues regarding the Medicare program, such as payment to health plans and providers, and access to and quality of care for Medicare beneficiaries.

Medicare Shared Savings Program (MSSP) is intended to facilitate coordination among health care providers in order to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce avoidable costs. Providers interested in participating in the MSSP may do so by creating or participating in an Accountable Care Organization (ACO). This Shared Savings Program aims to promote accountability for beneficiary care, coordinate care for all services provided, and encourage investment in health care infrastructure.

Medicare Star Rating is a system for Medicare Advantage plans is administered by CMS and was implemented to rate MA plans according to the quality of their care on five domains (on a scale of 1 to 5) and to make quality data more transparent. Under the ACA, CMS will provide bonus payments to plans that have received a star rating of 4 or above. CMS is looking to expand the bonus payments to plans that have received a rating of 3 or 3.5 stars.

Medigap refers to supplemental private insurance plans that pays for some of the health care costs that traditional Medicare coverage does not cover, including Part B services and the Part A hospital deductible.

Pioneer Accountable Care Organizations is a CMMI initiative designed to support organizations with experience operating as ACOs or in similar arrangements to provide coordinated care to beneficiaries at a lower cost to Medicare. The Pioneer ACO Model tests the impact of different payment arrangements over a three year period. These models involve Pioneer ACO providers transitioning to the majority of their payment based on quality and efficiency (not quantity of services) within three years.

Premium Support is a health care program where beneficiaries are guaranteed a set federal payment to help cover their health care costs.

Primary Care Medical Home (PCMH) is a health care delivery model where patient treatment is coordinated through their primary care provider. The primary care provider typically receives a case-based payment for these services and must meet quality and other performance standards.

Safe Harbor Guidelines allows for certain types of transactions that are not considered criminal under anti-kickback laws.

Scope of Practice Laws are state laws that define the clinical services that nurses, pharmacists, and other non-physician health professionals can provide.

Section 1115 Medicaid Waivers provide states with funding to test new approaches to Medicaid that differ from statutory coverage requirements, but are expected to provide equivalent or better coverage at no higher cost. States generally operate Medicaid programs under Section 1115 waivers today, which they negotiate with the federal government to enact payment and delivery reforms such as managed-care programs, special benefits, and financing for populations with special needs. Section 1115 waivers are required to be budget neutral for the federal government, compared to the usual Medicaid statutory requirements.

Stark Law limits certain physician referrals for Medicare services if the physician has a financial relationship with the entity receiving Medicare payments and prohibits the entity from presenting claims for those referred services.

Sustainable Growth Rate (SGR) is the formula currently used by CMS to control Medicare spending on physician services. CMS sets a target SGR each year and develops a conversion factor that is used if expenditures exceed the target SGR. While physician payments have regularly exceeded the target SGR, Congress has stepped in and adjusted or suspended the SGR to prevent a cut in physician payments.

Tax Exclusion for Employer Provided Health Insurance excludes employer-provided health insurance benefits from taxable income and is considered a tax expenditure because it costs the federal government approximately $250 billion in lost revenue each year.

Value-Based Purchasing features additional payments to providers when they perform well on measures of value, such as improved preventative screenings or chronic disease management, and greater efficiency in care. By tying the financial incentives with quality measures, providers are expected to improve quality and achieve better health outcomes.

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California Employer Health Benefits Survey: Fewer Covered, More Cost

APRIL 2013

Introduction

Employer-based coverage is the leading source of health insurance in California as well as nationally. This report of selected findings from the 2012 California Employer Health Benefits Survey provides a snapshot of the employer-based coverage landscape in the lead-up to implementation of the Affordable Care Act (ACA) in 2014. The percentage of employers reporting that they offer coverage continues its decline, with only 60% now offering insurance to employees. More than one-third of surveyed firms said they are increasing the premium cost to their workers in the coming year, and almost one-fourth plan to increase employees' deductibles.

KEY FINDINGS INCLUDE:

- The proportion of California employers offering coverage has declined significantly over the last decade, from 71% in 2002 to 60% in 2012.
- Higher offering rates are associated with larger firms, firms with higher wages, and firms with fewer part-time workers.
- Since 2002, premiums in Caifornia rose by 169.7%, more than five times the 31.5% increase in the state's overall inflation rate.
- Average monthly premiums for single coverage in California were $545 in 2012, compared to $468 nationally. For family coverage, monthly premiums were $1,386 in California and $1,312 nationally.
- More than one-quarter of workers in small firms had a deductible of $1,000 or more for single coverage in 2012, up from just 7% in 2006. In large firms, only 8% had a deductible of $1,000 or more.
- Twenty-one percent of California firms reported that they increased workers' share of the premium in the preceding year, while 17% reduced benefits or increased cost-sharing.

Information on the survey methodology is available on page 19.

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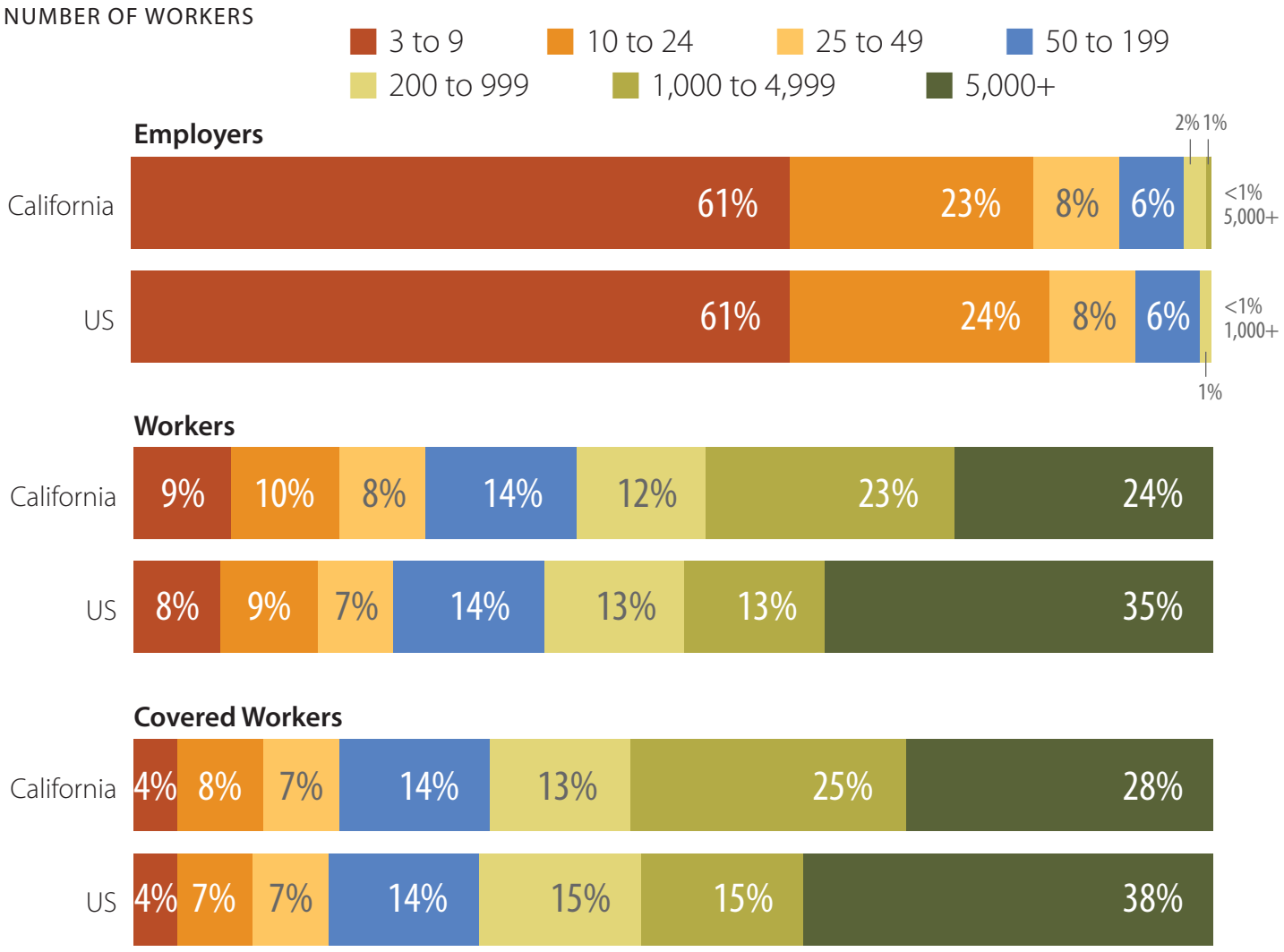
Employers, Workers, and Covered Workers, by Firm Size

California vs. the United States, 2012



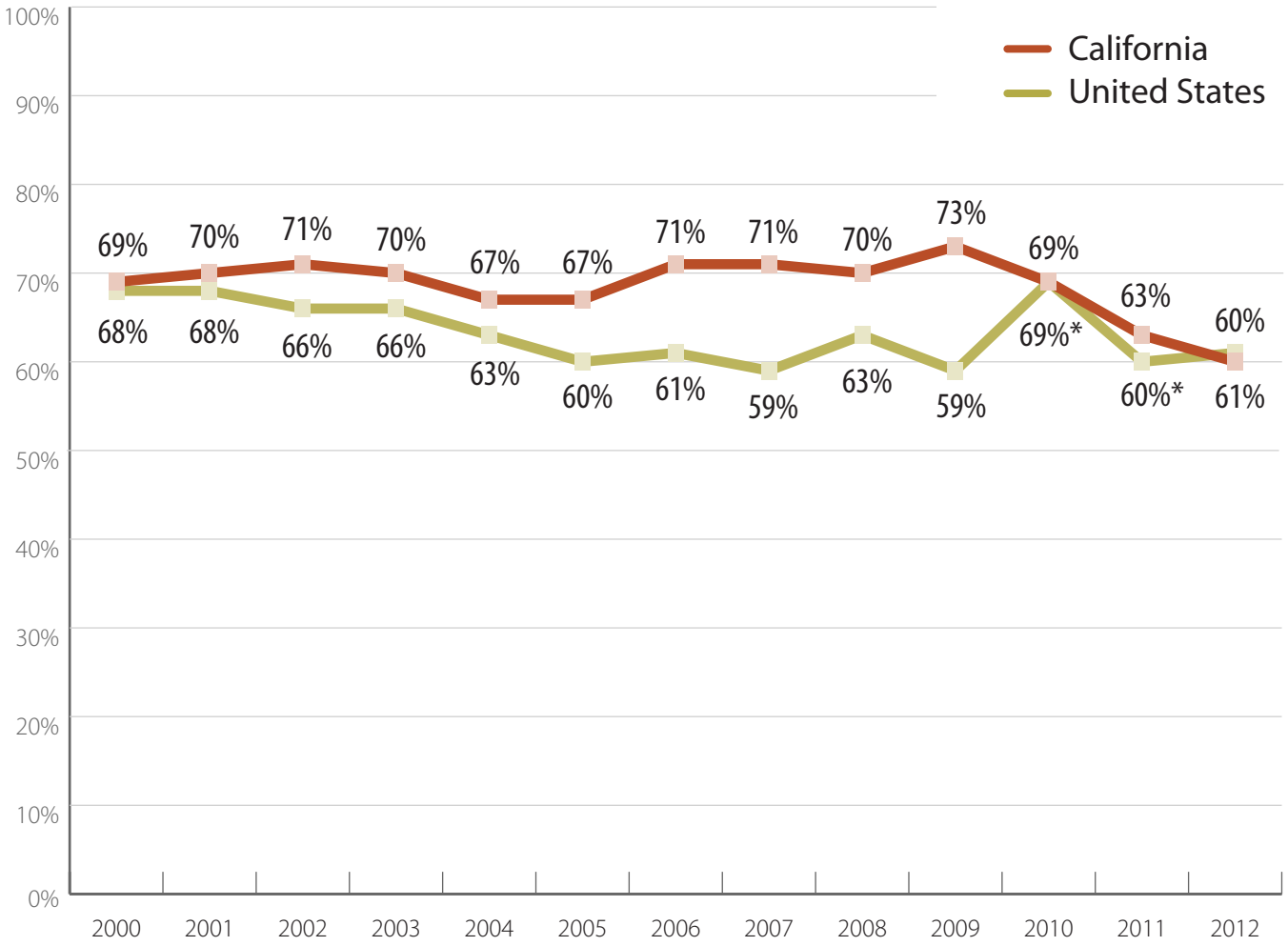
Notes: Tests found no statistically different distributions between California and the United States. Values may not add to 100% due to rounding.

Sources: California HealthCare Foundation/NORC California Employer Health Benefits Survey: 2012; Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 2012.

The vast majority (92%) of California firms have fewer than 50 employees, but represent only 27% of workers and 19% of covered workers.

Employers Offering Coverage

California vs. the United States, 2000 to 2012

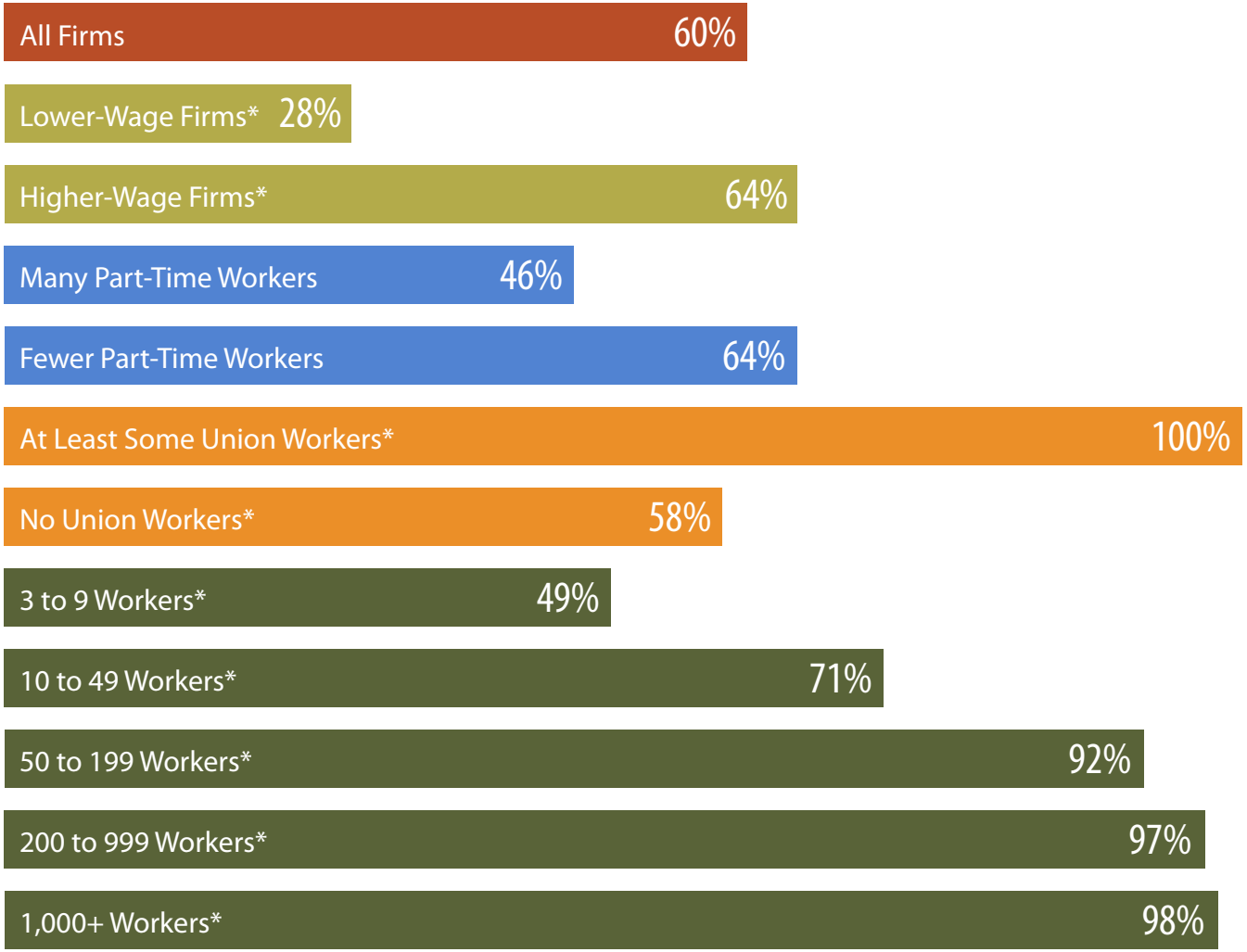


*Estimates are statistically different from the previous year shown.

Sources: California HealthCare Foundation/NORC California Employer Health Benefits Survey: 2007–2012; CHCF/HSC California Employer Health Benefits Survey: 2005–2006; CHCF/HRET California Employer Health Benefits Survey: 2004; Kaiser/HRET California Employer Health Benefits Survey: 2000–2003; Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 2000–2012.

The percentage of California employers reporting that they offer coverage has declined significantly. As of 2012, it was comparable to the national offer rate.

Employers Offering Coverage, by Firm Characteristics
California, 2012



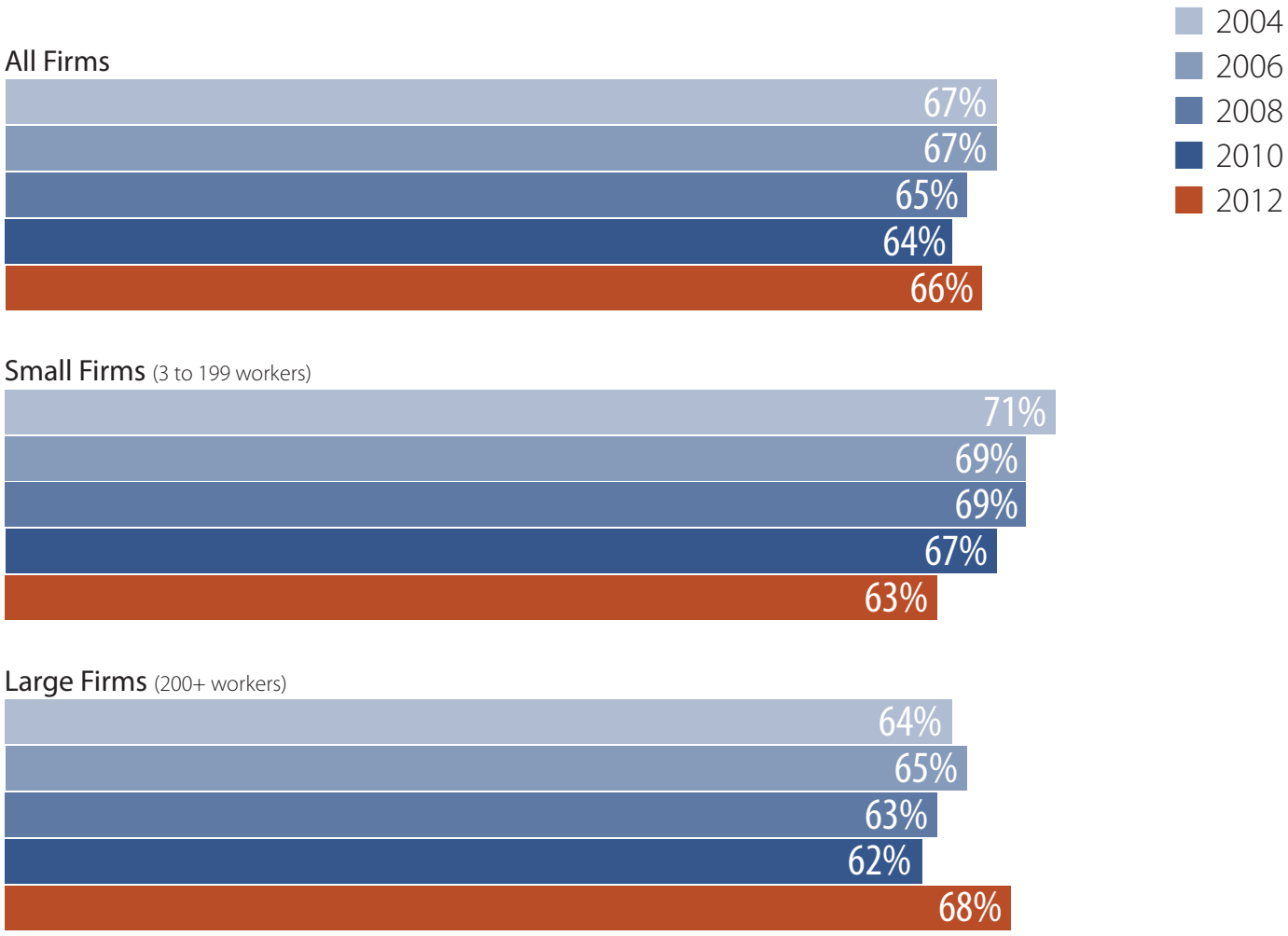
*Estimate is statistically different from all other firms.

Note: Lower-wage firms are those in which at least 35% of workers earn $24,000 or less per year. Higher-wage firms are the inverse. Firms with many part-time workers are those in which at least 35% of workers work part time. Firms with fewer part-time workers are the inverse.

Source: California HealthCare Foundation/NORC California Employer Health Benefits Survey: 2012.

Higher offering rates are associated with larger firms, firms with higher wages, and firms with fewer part-time workers. Only 28% of lower-wage firms offered health benefits in 2012, versus 64% of higher-wage firms.

Worker Coverage Rates Among Firms Offering Health Benefits
by Firm Size, California, 2004 to 2012



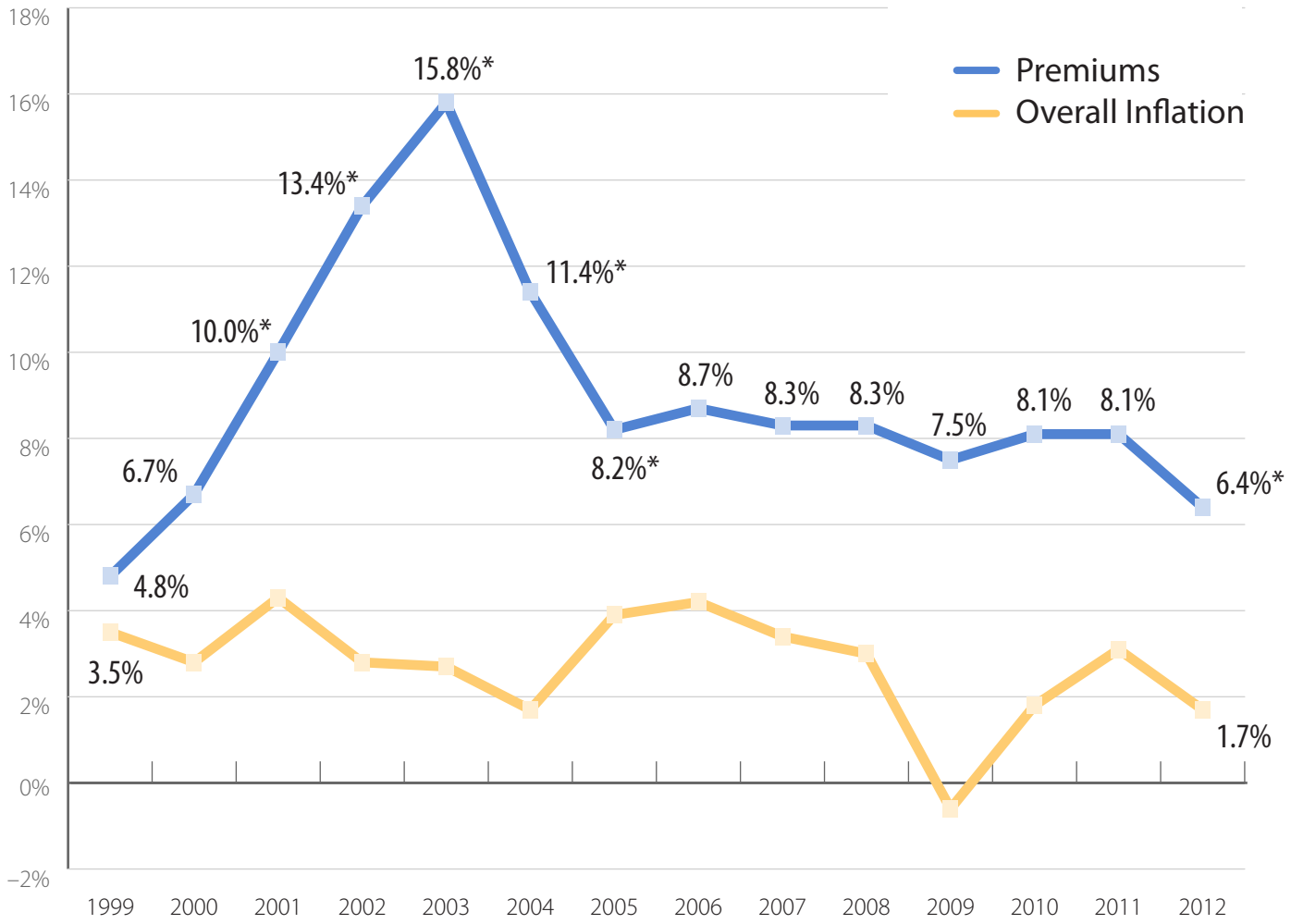
Note: Tests found no statistically different estimates from previous year shown within firm size.

Sources: California HealthCare Foundation/NORC California Employer Health Benefits Survey: 2008–2012; CHCF/HSC California Employer Health Benefits Survey: 2006; CHCF/HRET California Employer Health Benefits Survey: 2004.

Overall insurance coverage rates have been fairly stable since 2004.

Premium Increases Compared to Inflation

Family Coverage, California, 1999 to 2012



*Estimates are statistically different from the previous year shown.

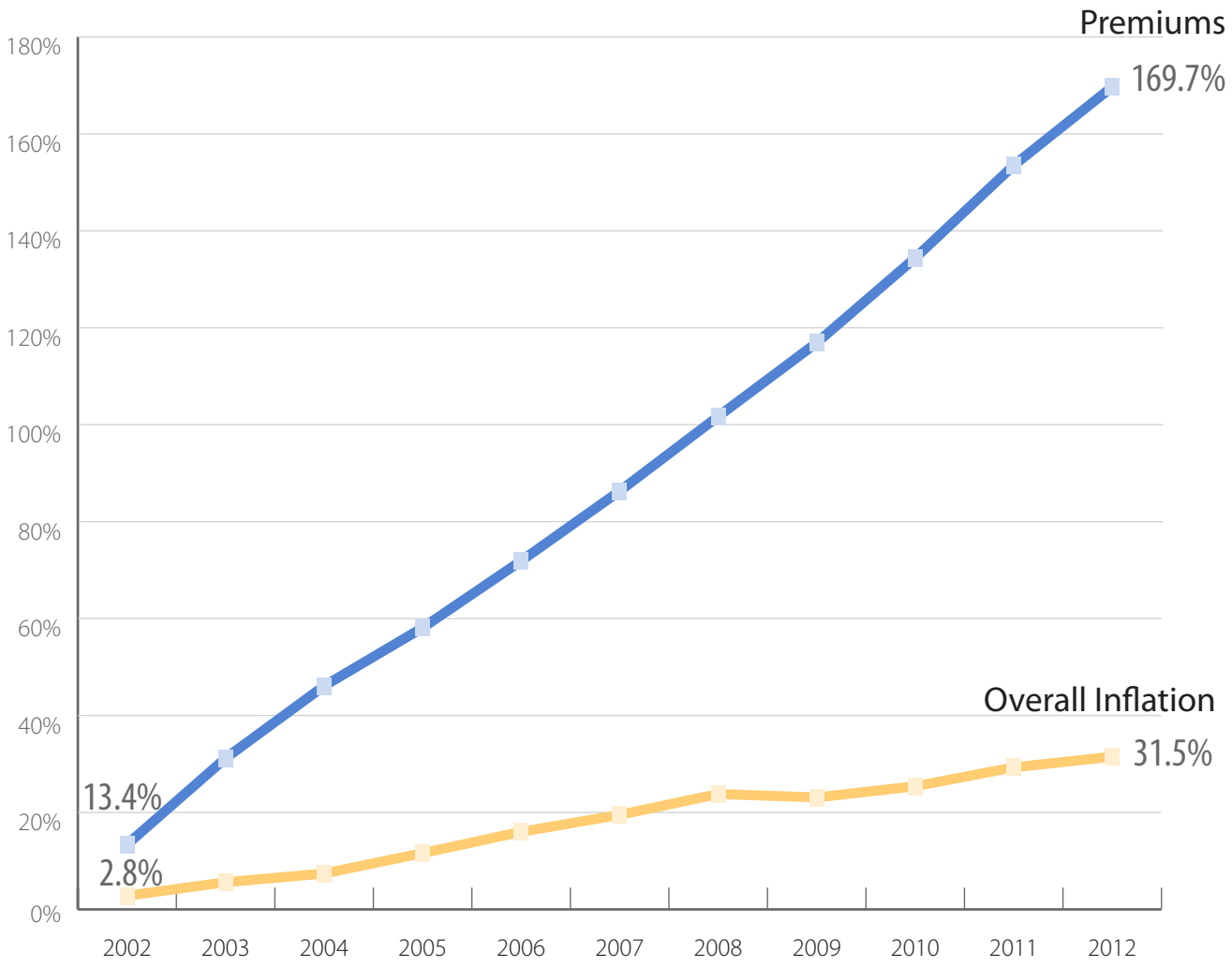
Note: Information on the calculation of premium changes is available on page 19.

Sources: California HealthCare Foundation/NORC California Employer Health Benefits Survey: 2007–2012; CHCF/HSC California Employer Health Benefits Survey: 2005–2006; CHCF/HRET California Employer Health Benefits Survey: 2004; Kaiser/HRET California Employer Health Benefits Survey: 1999–2003; California Division of Labor Statistics and Research, Consumer Price Index, California Average of Annual Inflation (April to April): 1999–2012.

Health insurance premiums for family coverage in California grew by only 6.4% in 2012, a significant decline from 2011. However, premiums continued to rise much faster than the overall California inflation rate.

Cumulative Premium Increases Compared to Inflation

Family Coverage, California, 2002 to 2012



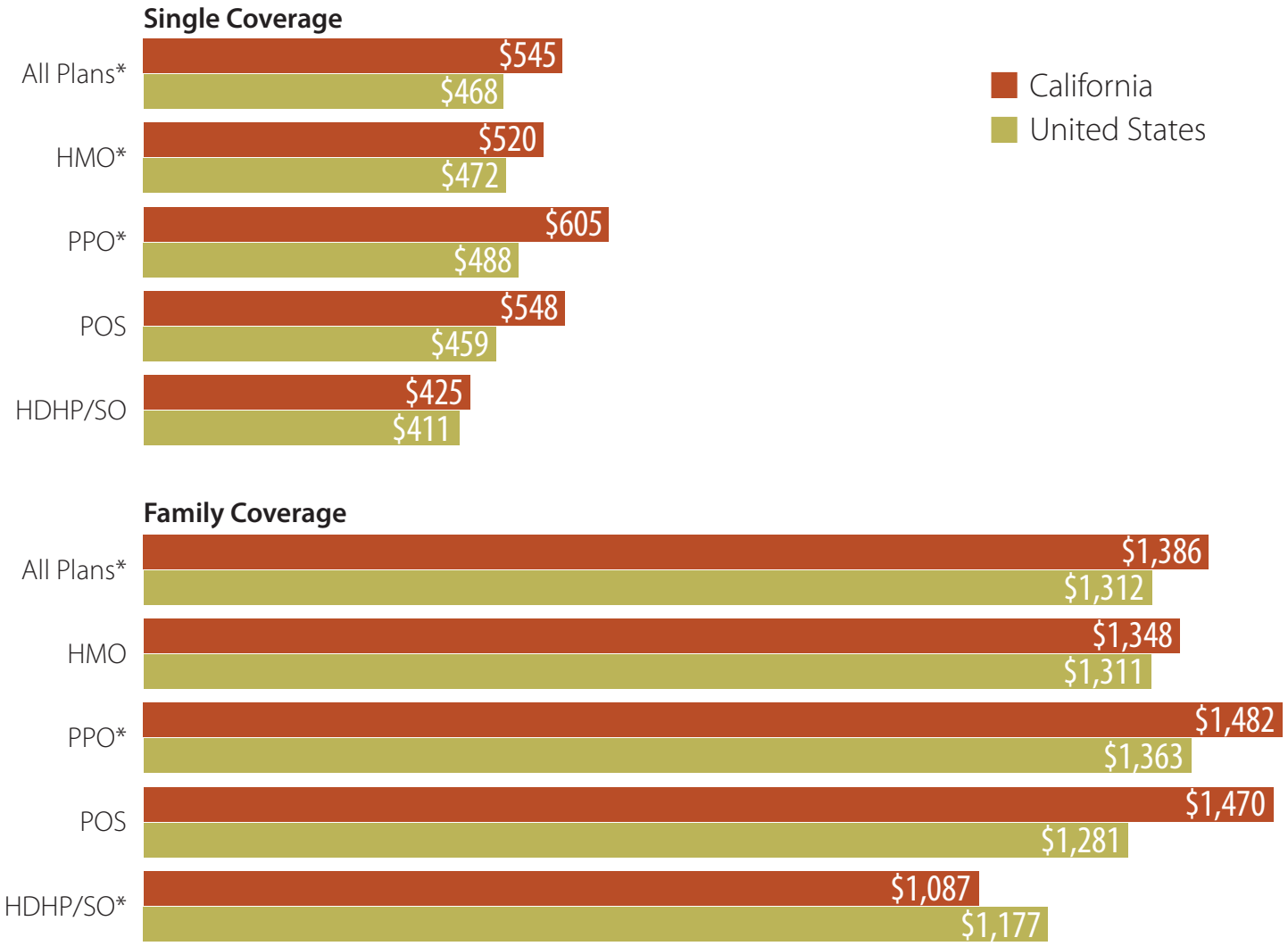
Note: Information on the calculation of premium changes is available on page 19.

Sources: California HealthCare Foundation/NORC California Employer Health Benefits Survey: 2007–2011; CHCF/HSC California Employer Health Benefits Survey: 2005–2006; CHCF/HRET California Employer Health Benefits Survey: 2004; Kaiser/HRET California Employer Health Benefits Survey: 2002–2003; California Division of Labor Statistics and Research, Consumer Price Index, California Average of Annual Inflation (April to April): 2002–2012.

Since 2002, health insurance premiums in California have increased by 169.7%, more than five times the 31.5% increase in the state's overall inflation rate.

Average Monthly Premiums, by Plan Type

California vs. the United States, 2012

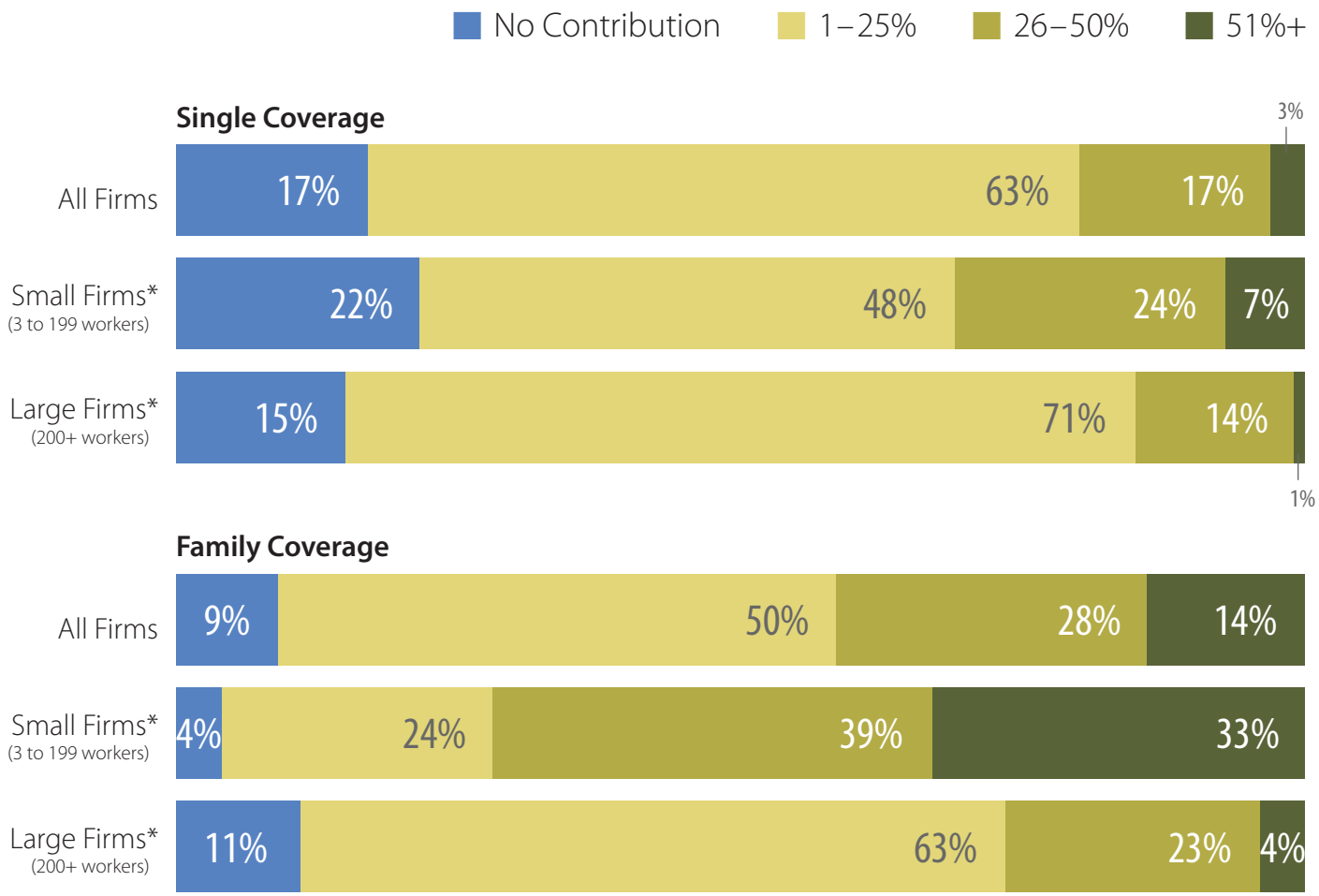


*Estimates are statistically different between California and the United States.
Note: HDHP/SO means high-deductible health plan with a savings option.

Sources: California HealthCare Foundation/NORC California Employer Health Benefits Survey: 2012; Kaiser/HRET Employer Health Benefits Survey: 2012.

Average monthly premiums for both single and family coverage were significantly higher in California than nationally in 2012.

Worker Share of Premium, by Firm Size
California, 2012



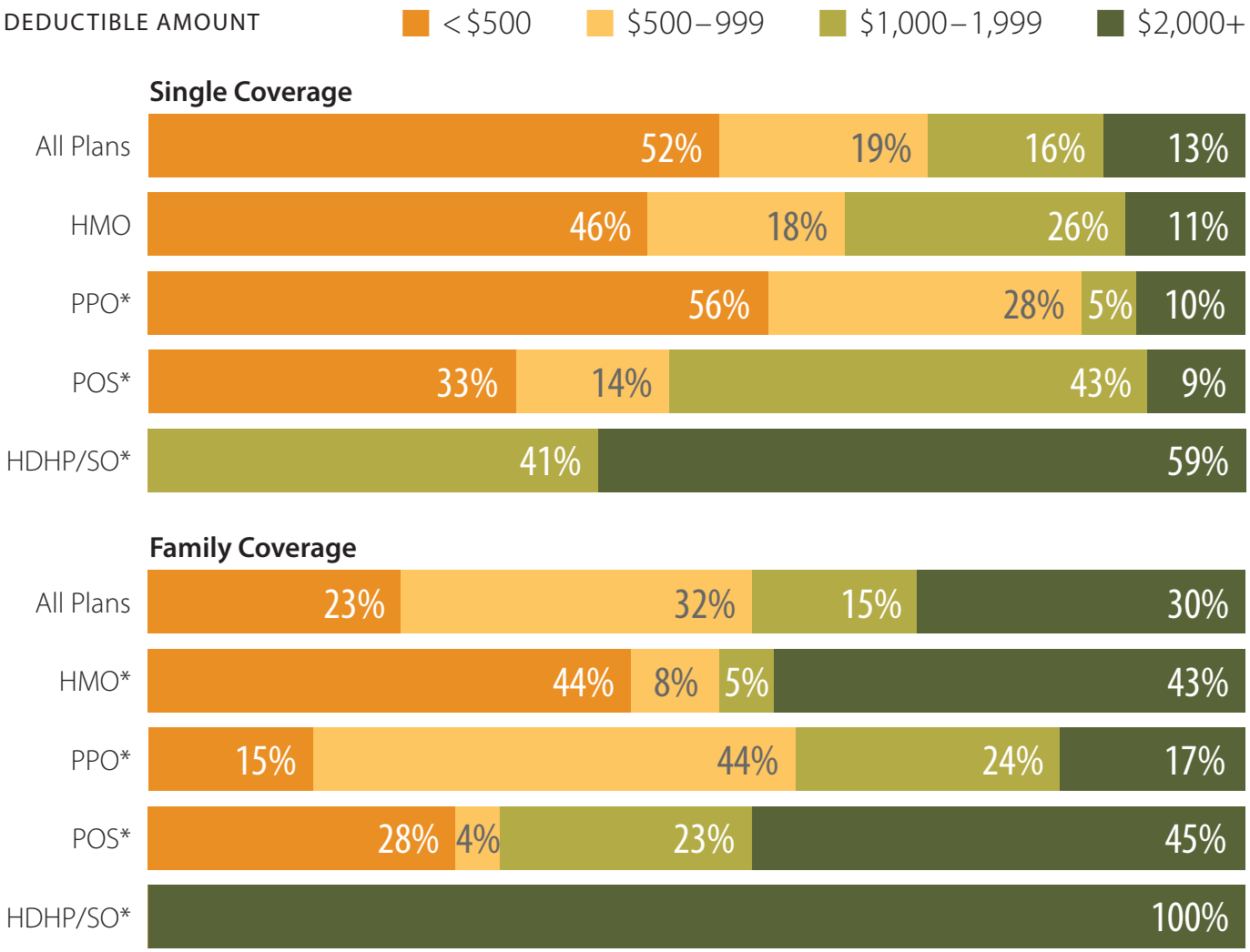
*Difference is statistically different between small and large firms for single and family contributions.

Note: Values may not add to 100% due to rounding.

Source: California HealthCare Foundation/NORC California Employer Health Benefits Survey: 2012.

In 2012, 17% of covered California employees worked for firms that paid the full premium for single coverage. Employees of small firms were much more likely to pay more than half of the premium for family coverage than employees of large firms.

Workers with a Deductible, Single or Family Coverage
by Plan Type, California, 2012



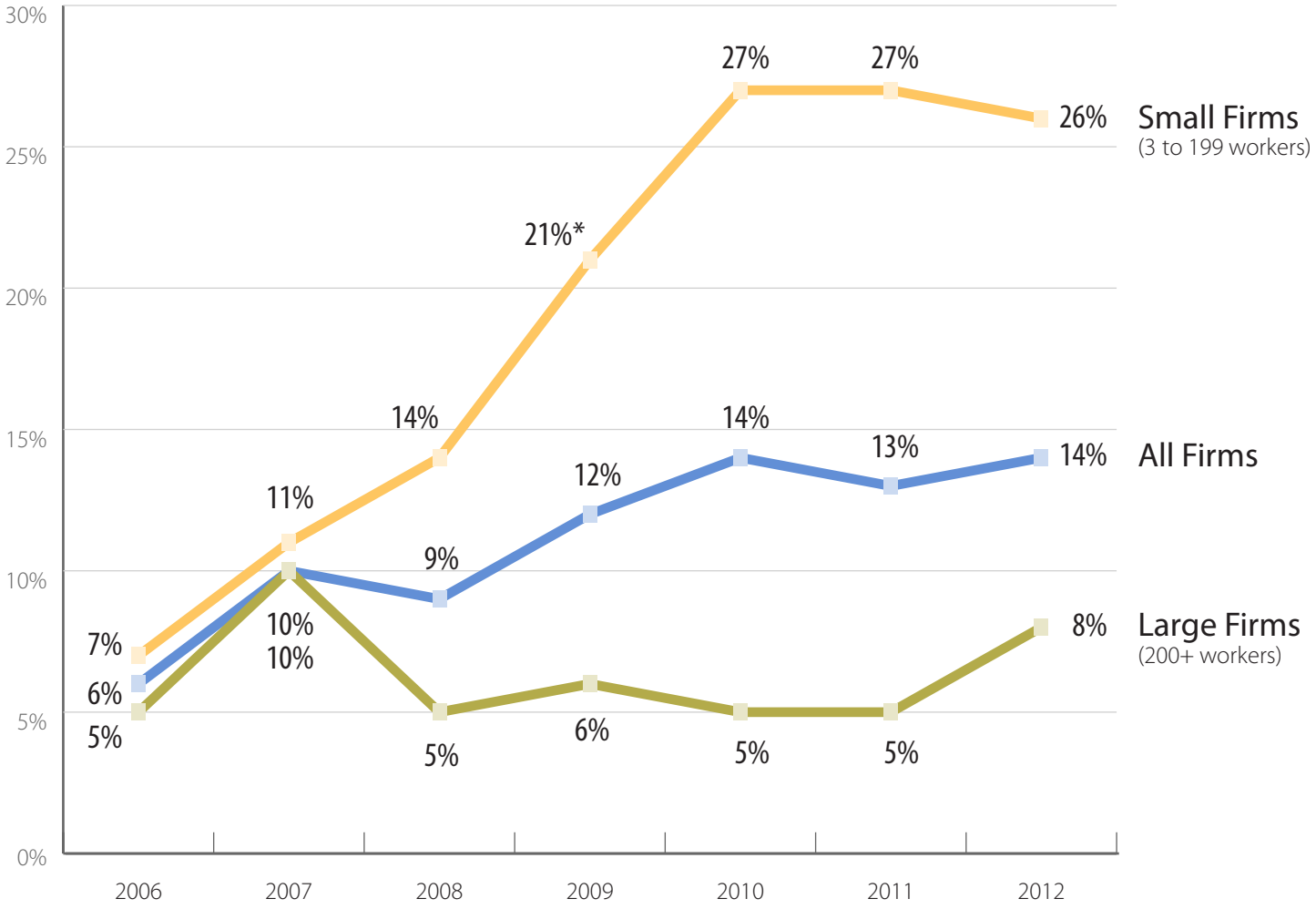
*Distribution is statistically different from all plans.

Notes: Values may not add to 100% due to rounding. HDHP/SO means high-deductible health plan with a savings option.

Source: California HealthCare Foundation/NORC California Employer Health Benefits Survey: 2012.

Among California workers with an annual deductible for single coverage, 52% had a deductible of less than $500, while 29% had a deductible of $1,000 or more. Among workers with an aggregate family deductible — a total amount that applies to the entire family — 30% faced an annual family deductible of $2,000 or more.

Workers with a Large Deductible ($1,000+), Single Coverage
by Firm Size, California, 2006 to 2012



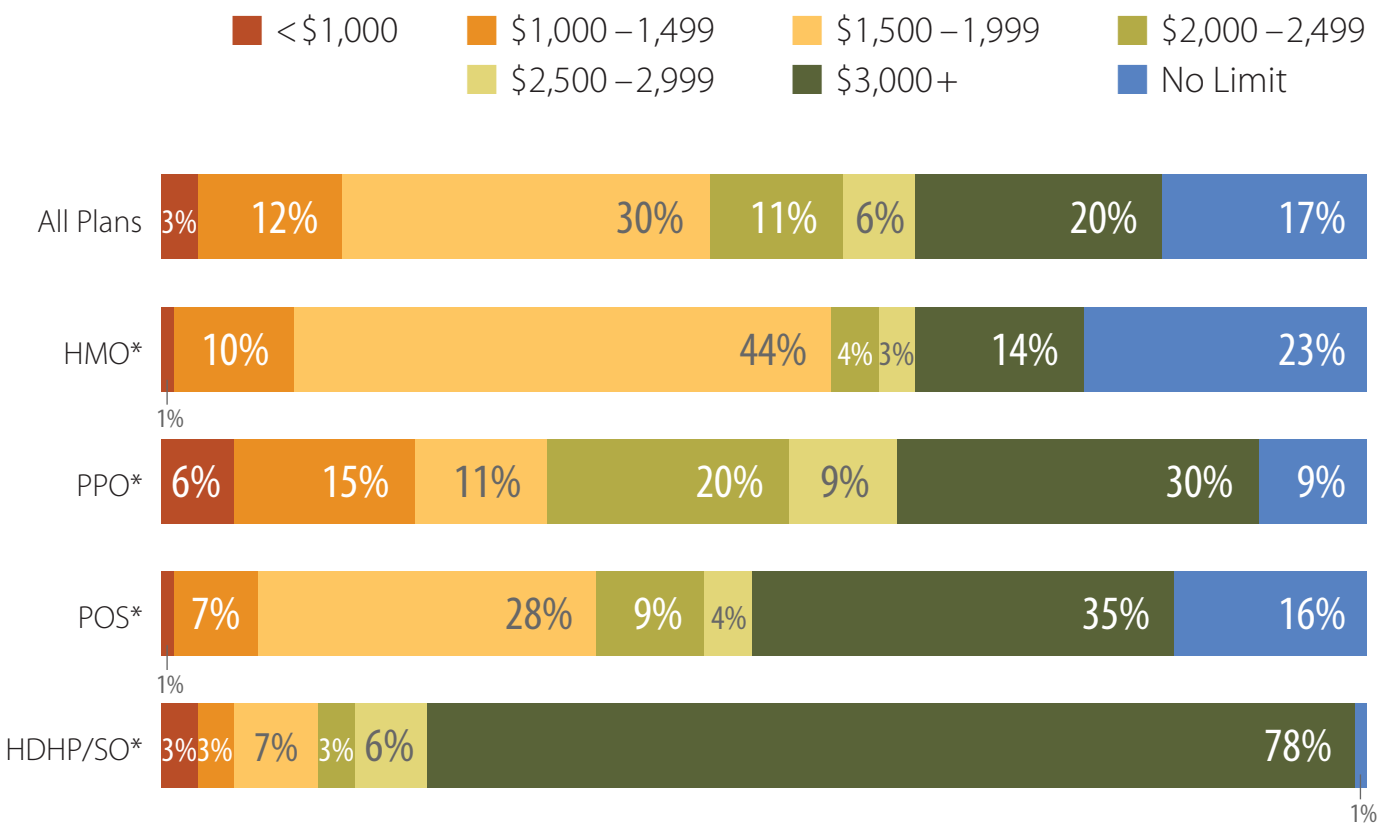
*Estimate is statistically different from previous year shown by firm size.

Source: California HealthCare Foundation/NORC California Employer Health Benefits Survey: 2006–2012.

Twenty-six percent of workers in small firms had a deductible of $1,000 or more for single coverage in 2012, up from just 7% in 2006. In large firms, only 8% had a deductible of $1,000 or more.

Annual Out-of-Pocket Limits, Single Coverage
by Plan Type, California, 2012

PERCENTAGE OF WORKERS WITH SPECIFIED LIMIT RANGES



*Distribution is statistically different from all plans.

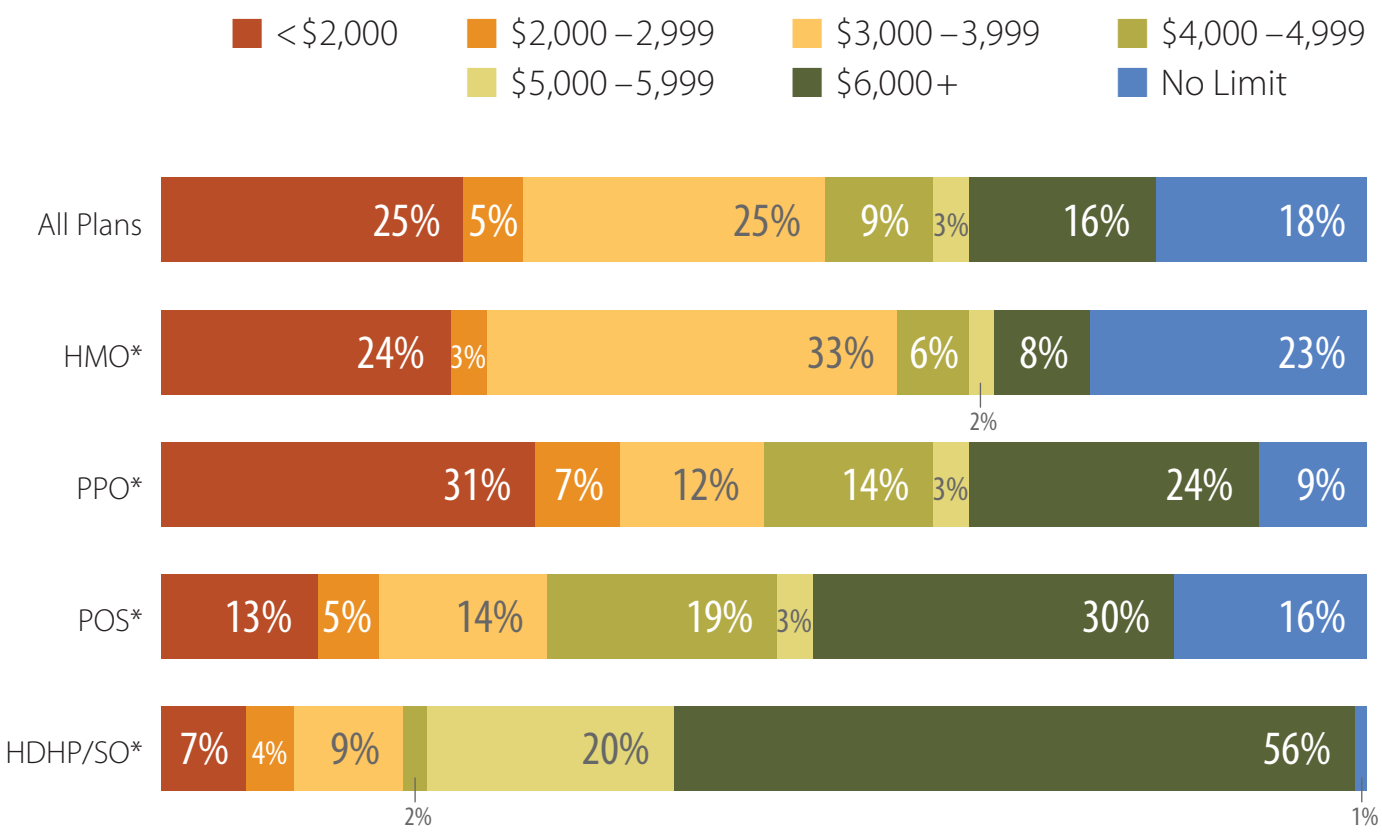
Notes: Because HMOs typically provide very comprehensive coverage, not having a limit on out-of-pocket expenditures does not expose enrollees to the same financial risk as it could in other plan types. Values may not add to 100% due to rounding.

Source: California HealthCare Foundation/NORC California Employer Health Benefits Survey: 2012.

The large majority of covered workers with single coverage (83%) had an annual out-of-pocket limit. Workers in a high-deductible health plan with a savings option (HDHP/SO) were the most likely to have a high limit; 78% had a limit of $3,000 or more.

Annual Out-of-Pocket Limits, Family Coverage
by Plan Type, California, 2012

AMONG WORKERS WITH AGGREGATE LIMIT, PERCENTAGE WITH SPECIFIED RANGES



*Distribution is statistically different from all plans.

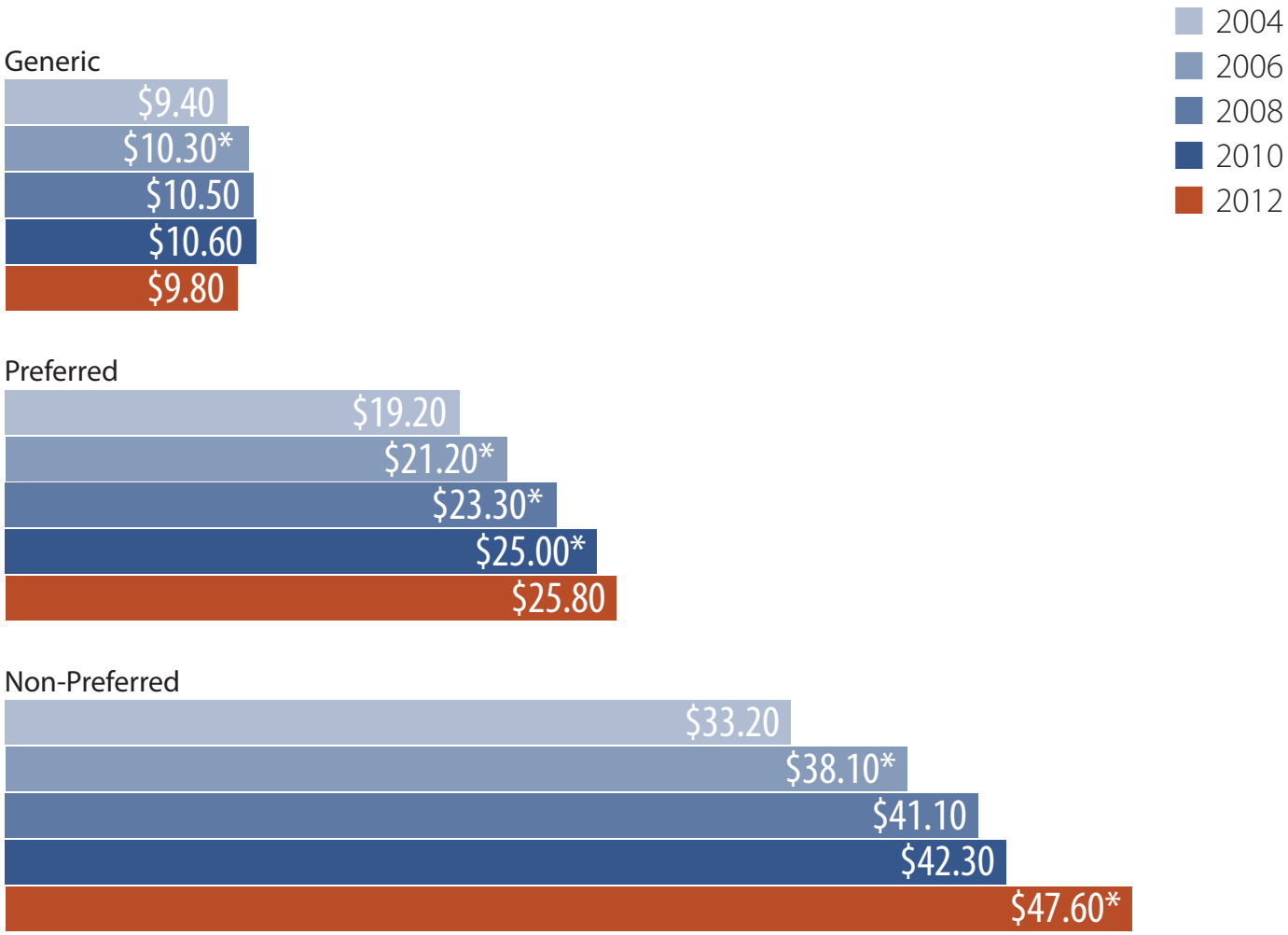
Notes: Because HMOs typically provide very comprehensive coverage, not having a limit on out-of-pocket expenditures does not expose enrollees to the same financial risk as it could in other plan types. Values may not add to 100% due to rounding.

Source: California HealthCare Foundation/NORC California Employer Health Benefits Survey: 2012.

Among covered workers with family coverage with an aggregate limit, 82% had an annual out-of-pocket limit. Fifty-six percent of workers in a high-deductible health plan with a savings option (HDHP/SO) had a limit of $6,000 or more.

Average Prescription Copayments, by Drug Type

California, 2004 to 2012, Selected Years

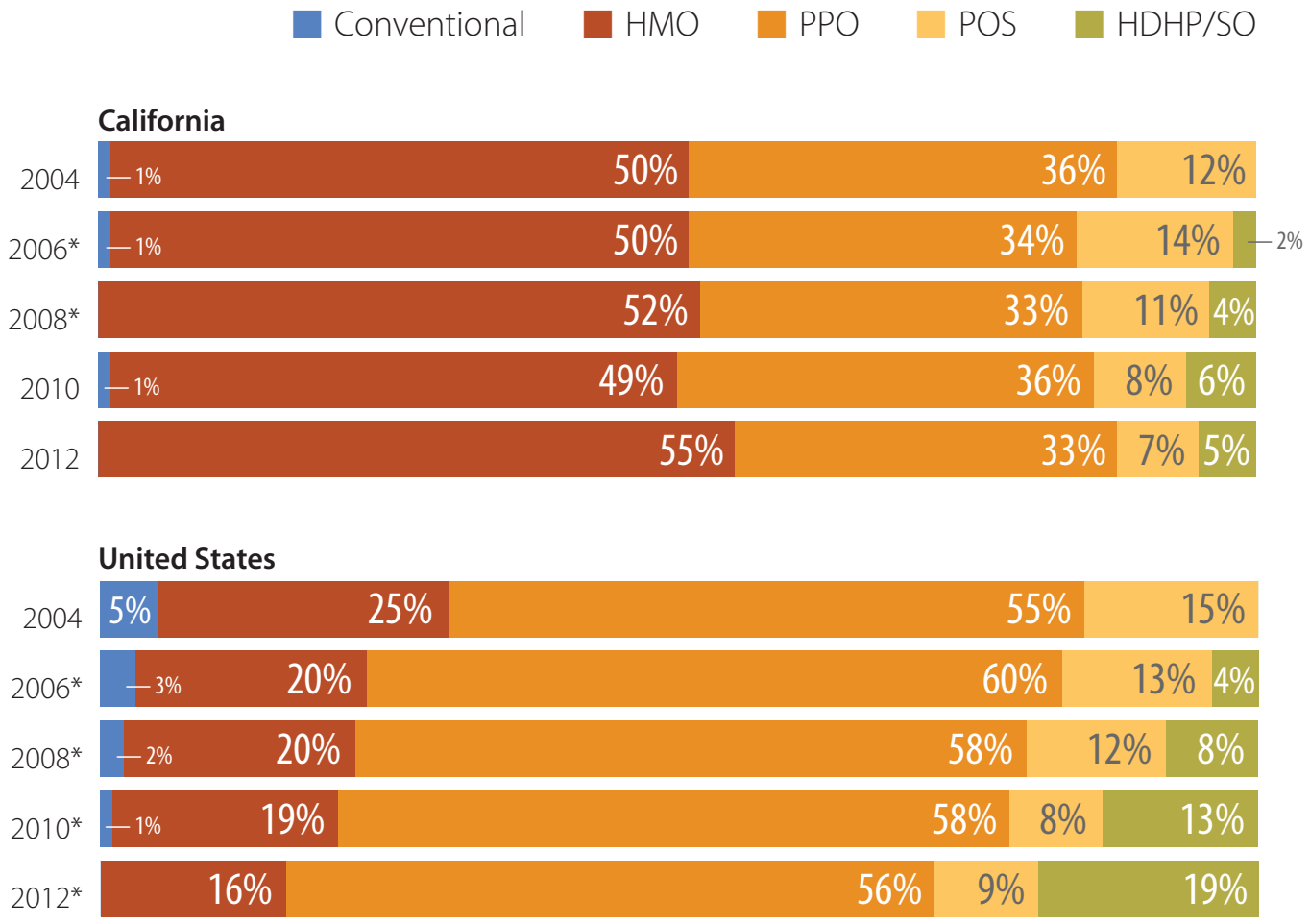


*Estimate is statistically different from previous year shown.

Sources: California HealthCare Foundation/NORC California Employer Health Benefits Survey: 2008, 2010, 2012; CHCF/HSC California Employer Health Benefits Survey: 2006; CHCF/HRET California Employer Health Benefits Survey: 2004.

In 2012, average copayments for generic drugs ($9.80) were less than half of those for preferred drugs ($25.80), and less than one-quarter of those for non-preferred drugs ($47.60).

Enrollment of Covered Workers, by Plan Type,
California vs. the United States, 2004 to 2012, Selected Years



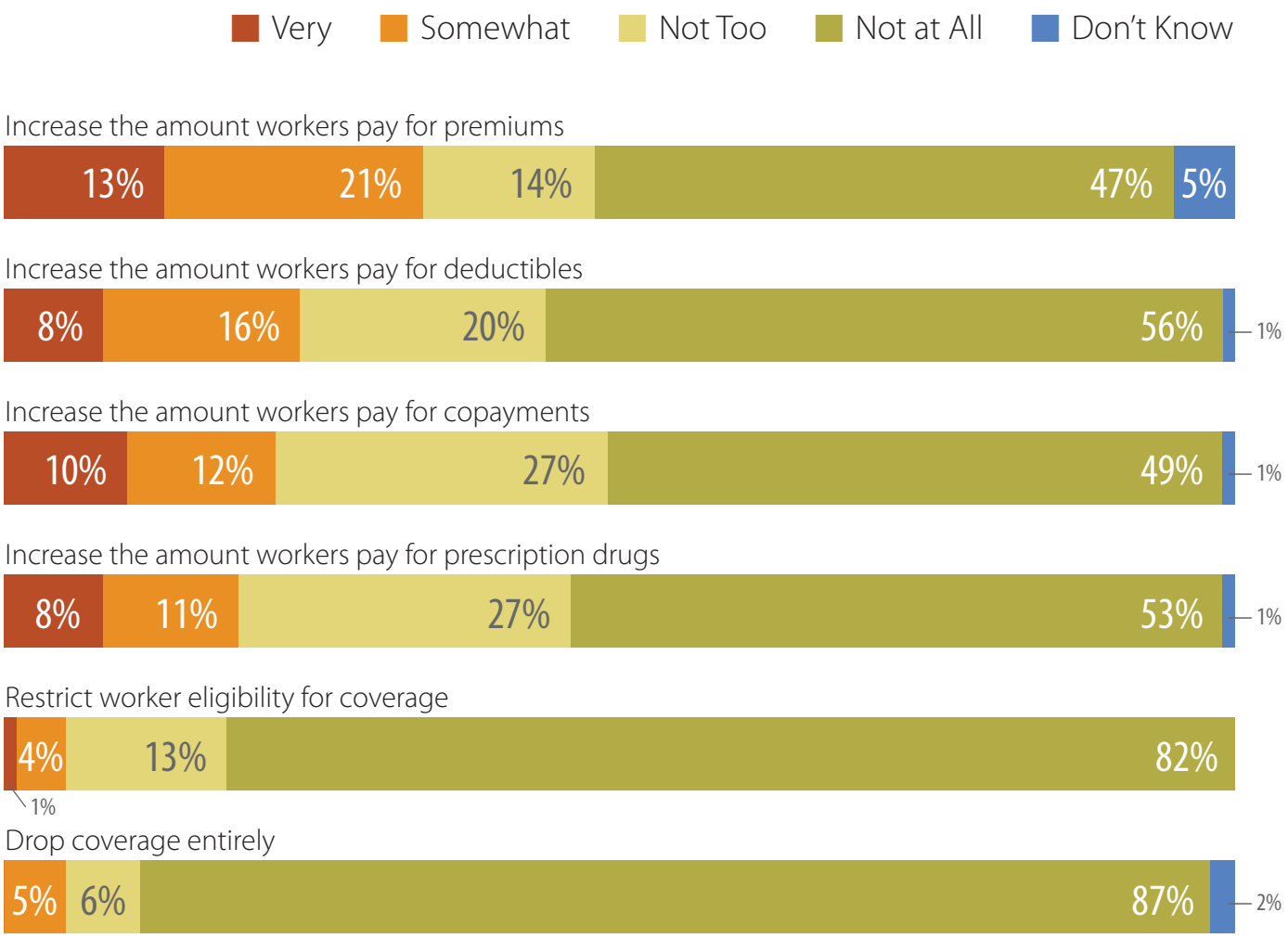
*Distribution is statistically different from previous year shown.

Notes: Conventional fee-for-service plan enrollment in California in 2008 and 2012 was less than 1%, and conventional plan enrollment in the US was less than 1% in 2012. Due to the addition of HDHP in 2006, no test was conducted comparing 2006 with 2004. Values may not add to 100% due to rounding. HDHP/SO means high-deductible health plan with a savings option.

Sources: California HealthCare Foundation/NORC California Employer Health Benefits Survey: 2008, 2010, 2012; CHCF/HSC California Employer Health Benefits Survey: 2006; CHCF/HRET California Employer Health Benefits Survey: 2004; Kaiser/HRET Employer Health Benefits Survey: 2004–2012.

California workers have been consistently more likely to enroll in HMOs than covered workers nationally. PPOs continue to be less popular in California than in the US. California enrollment in high-deductible plans with a savings option has been stable since 2008. This contrasts with national trends, in which HDHP/SO plans are growing in popularity, while HMOs are declining.

Likelihood of Firms Making Changes in the Next Year
by Type of Change, California, 2012



Note: Values may not add to 100% due to rounding.

Source: California HealthCare Foundation/NORC California Employer Health Benefits Survey: 2012.

About one-third of California employers reported they are very likely or somewhat likely to increase the amount that their workers pay for premiums in the next year, while 24% said they are very or somewhat likely to increase employees' deductibles.

Firms That Made Changes in the Past Year
by Firm Size and California Region, 2012

	REDUCED SCOPE OF HEALTH BENEFITS OR INCREASED COST SHARING	INCREASED WORKERS' SHARE OF PREMIUM
FIRM SIZE		
All Small Firms (3 to 199 workers)	**16%***	**20%***
All Large Firms (200+ workers)	**36%***	**51%***
• 200 to 999 workers	36%*	49%*
• 1,000+ workers	36%*	53%*
REGION		
Los Angeles	21%	25%
San Francisco	20%	21%
Rest of State	13%	19%
All Firms	**17%**	**21%**

*Estimate is statistically different from all other firms.

Note: Los Angeles and San Francisco are defined as the metropolitan statistical area (MSA).

Source: California HealthCare Foundation/NORC California Employer Health Benefits Survey: 2012.

Twenty-one percent of California firms increased workers' share of the premium in the preceding year, while 17% reduced the scope of health benefits or increased cost-sharing. Large firms were significantly more likely to make these changes than smaller firms.

Methodology

The *California Employer Health Benefits Survey* is produced jointly by the California HealthCare Foundation (CHCF) and NORC at the University of Chicago. The survey was designed and analyzed by researchers at NORC, and administered by National Research LLC (NR). The findings are based on a random sample of 659 interviews with employee benefit managers in private firms in California. NR conducted interviews from August to December 2012. As with prior years, the sample of firms was drawn from the Dun & Bradstreet list of private employers with three or more workers. The margin of error for responses among all employers is +/– 3.8%; for responses among employers with 3 to 199 workers, it is +/– 5.0%; among employers with 200+ workers, it is +/– 5.9%. Some exhibits do not sum to 100% due to rounding effects.

The Kaiser Family Foundation sponsored this survey of California employers from 2000 to 2003. A similar employer survey was also conducted in 1999 in California, in conjunction with the Center for Health and Public Policy Studies at the University of California, Berkeley. The Health Research and Educational Trust (HRET) collaborated on these surveys from 1999 to 2004. The Center for Studying Health System Change collaborated on these surveys from 2005 to 2006.

This survey instrument is similar to a national employer survey conducted annually by the Kaiser Family Foundation and HRET. The US results in this study are from the published reports. A full analysis of the US dataset is available on the foundation's website at www.kff.org. Both the California and US surveys asked questions about: health maintenance organizations (HMO), preferred provider organizations (PPO), point-of-service (POS) plans, and high-deductible health plans with a savings option (HDHP/SO). Conventional (fee-for-service) plans are generally excluded from the plan type analyses because they comprise such a small share of the California market.

Many variables with missing information were identified as needing complete information within the database. To control for item nonresponse bias, missing values within these variables were imputed using a hot-deck approach. Calculation of the weights follows a common approach. First, the basic weight is determined, followed by a survey nonresponse adjustment. Next, the weights are trimmed in order to reduce the influence of weight outliers. Finally, a post-stratification adjustment is applied.

All statistical tests in this chart pack compare either changes over time, a plan-specific estimate with an overall estimate, or subcategories versus all other firms (e.g., firms with 3 to 9 workers vs. all other firms). Tests include t-tests and chi-square tests, and significance was determined at $p < 0.05$ level. Due to the complex nature of the design, standard errors are calculated in SUDAAN.

A important note about the methodology: Rates of change for total premiums, for worker or employer contributions to premiums, and other variables calculated by comparing dollar values in this report to data reported in past CHCF or KFF publications should be used with caution, due to both the survey's sampling design and the way in which plan information is collected. Rates calculated in this fashion not only reflect a change in the dollar values but also a change in enrollment distribution, thus creating a variable enrollment estimate. However, rates of change in premiums are collected directly as a question in the California survey. This rate of change holds enrollment constant between the current year and the previous year, thus creating a fixed enrollment estimate. Because the survey does not collect information on the rate of change in other variables, additional rates are not reported. The national survey conducted by Kaiser/HRET, however, stopped directly collecting rates of change in premiums in its 2008 survey. Therefore, the rate of change in total premiums in the US provided in this report uses a variable enrollment estimate.

Please note that due to a change in the post-stratification methods applied in 2003, the survey data published in this report may vary slightly from reports published prior to 2003.

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Health Insurance Exchanges In Switzerland And The Netherlands Offer Five Key Lessons For The Operations Of US Exchanges

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ABSTRACT Since the 1990s some European countries have had regulated health insurance exchanges or have incorporated elements of exchange markets into their health systems. Health reforms in Switzerland and the Netherlands in 1996 and 2006, respectively, created managed competition in the countries' health insurance markets, which are somewhat analogous to the US state and federally operated health insurance exchanges scheduled to begin operations in 2013 under the Affordable Care Act. We review the Swiss and Dutch experience with exchanges and offer specific lessons for the US exchanges. First, risk-adjustment mechanisms—which provide premium adjustments intended to compensate health plans for enrolling people expected to have high medical costs—need to be sophisticated and continually updated. Second, it is important to determine why people eligible for coverage don't enroll and to craft responses that will overcome enrollment barriers. Third, applying for subsidies must be simple. Fourth, insurers will need bargaining power similar to that of providers to create a level playing field for negotiating about prices and quality of services, and interim cost containment measures may be necessary. Fifth and finally, insurers and consumers alike will need meaningful information about providers' costs and quality of care so they can become prudent purchasers of health services, since managed competition among health plans by itself will not substantially drive down health costs.

The health insurance exchanges now being created under the Affordable Care Act have features similar to those of the exchange markets that have been adopted in Europe. Countries with exchanges include Belgium, the Czech Republic, Germany, the Netherlands, Slovakia, and Switzerland. All of these countries have systems that allow people to choose periodically among risk-bearing insurance funds, often called sickness funds in Europe.[1,2]

The experiences of Switzerland and the Netherlands are particularly relevant because both countries created private insurance markets—in 1996 and 2006, respectively—that are similar to the exchanges and market dynamics at the heart of the Affordable Care Act. These two European markets also rely on offering people choices among private insurers, requiring people to purchase insurance, having standardized benefits packages, using community rating for premiums, and providing premium subsidies for lower-income people.

The Swiss and Dutch experiences with creating insurance exchanges in the context of health system reforms show that unforeseen issues often arise when legislation is implemented. In a recent article in the *New England Journal of*

Medicine, we pointed out two lessons from the Swiss and Dutch experiences that could be useful as the United States implements its exchanges. First, competitive insurance markets by themselves will not contain costs. Second, a good risk-adjustment formula is critical for achieving price competition among insurers.[3]

In this article we provide more details about how the Swiss and Dutch insurance markets have evolved. We first explain subtle points of the risk-adjustment lesson mentioned above, and we present two lessons pertinent to enrolling high numbers of uninsured people in policies sold in the exchanges. We then offer two lessons relevant to cost containment efforts. To set these lessons in context, we first briefly describe the Swiss and Dutch health reforms and the vision that motivated them. We then discuss the lessons that can be drawn from the two countries' experiences and conclude by discussing their implications for the United States.

Exchanges, Managed Competition, And Health Reform

In Europe managed competition in health care is seen as a way to provide incentives for markets to operate efficiently and to achieve societal goals of universal access to affordable, high-quality health care.[4–6] The health care sector of the economy is viewed as having three linked markets: health insurance coverage of individuals; health care purchasing, meaning insurer-provider contracting that could involve details about the way providers are paid and minimum quality goals, or that could simply be about an aggregate payment from the insurer to the provider; and health care provision. Insurers, providers, and individuals all have roles in these three linked markets as purchasers, suppliers, or consumers. The government's role is to provide oversight and regulations to promote price and quality competition among insurers and among health care providers.

In Switzerland and the Netherlands managed competition in health insurance markets requires that everyone purchase health insurance, with premium subsidies for lower-income people. Insurers must accept all applicants and may sell only policies that cover a structured set of benefits. Insurers must also "community rate" premiums for their policies—that is, insurers must sell a particular policy to everyone for the same premium, regardless of health status or claims history. Insurers can set different premiums for the same standardized policy, but everyone who buys a policy from a particular insurer pays the same premium. Both countries also use risk-adjustment mechanisms that allow for higher payments on behalf of enrollees expected to have very high costs.

The regulations and risk-adjustment processes are intended to promote efficiency by providing insurers with incentives to compete to lower costs and improve the quality of health care. The aim is not to have insurers compete to enroll only people with few health problems who are expected to have low health care costs.

In a health care system with managed competition in all three markets, insurers are expected to be prudent purchasers of care for their enrollees in the health care purchasing market. Insurers should vigorously negotiate with health care providers on price, volume, and quality of care. In the health care provision market, hospitals and other providers should compete for patients on the basis of quality of care and level of cost sharing required for some services.

In theory, with competitive forces in all three markets, providers that offer low-quality health services at expensive rates will have to improve their performance, reduce costs, or go out of business. This should result in improved quality of care and cost containment in the health system.

The health reforms in Switzerland and the Netherlands focused on creating managed competition in the countries' health insurance markets. Competition among insurers has been viewed as a necessary first step for improving health outcomes and slowing increases in health costs. The subsequent steps of establishing managed competition in the health care purchasing and provision markets are still works in progress in these two countries.

Swiss And Dutch Reforms

Some details about each country's health reforms are useful to consider before drawing lessons that might be relevant for the US exchanges. Exhibits 1 and 2 provide summaries of key characteristics of the Swiss and Dutch health systems and insurance exchange markets.

SWISS REFORMS Since 1996 Switzerland has required its citizens to purchase individual health insurance from one of the plans sold in their canton of residence. The country has twenty-six cantons that are member states of the federal state of Switzerland. The number of insurers selling policies differs across cantons, but on average people can choose from among fifty-nine insurers (Exhibit 2).[7]

Every insurer can offer several "basic" plans with standardized benefits; premiums are lower for plans with higher deductibles and managed care plans. Insurers may not reject applicants or earn profits on the basic plans. Premiums must

EXHIBIT 1

Key Characteristics Of Health Systems In The Netherlands And Switzerland

	Netherlands	Switzerland
Basic characteristics	Universally mandated private insurance that covers acute care only (long-term care is covered by separate insurance) National exchange Available to all residents and those paying Dutch payroll tax Standardized benefit package	Universally mandated private insurance that covers acute care and partly covers long-term care 26 regional (canton) exchanges Available to all residents Standardized benefit package
Open enrollment period	Once a year, but insurers must accept new applicants at any time	Twice a year
Funding of system	Community rated premiums, which fund approximately 50% of the system, vary by deductible level; average per month per person premium is $139 (€107); paid by consumer to insurer Income-related contributions, which fund approximately 45% of the system, equal 7.1% of the first $65,264 (€50,065) of income paid mostly by employer Government contribution, which funds approximately 5% of the system, covers those younger than age 18 Income-related contributions and government contributions are pooled in a central fund and allocated to insurers after risk adjustment	Community rated premiums vary by deductible level, age, and across cantons;[a] average per month per person premium is $372 (CHF 351) for ages ≥26, $312 (CHF 294) for ages 19–25, $88 (CHF 84) for ages ≤18; paid by consumer to insurer Government funding (mostly from cantons) subsidizes institutional providers (hospitals, long-term care institutions, home care providers), prevention, public health, and administration charges Premiums are pooled in a central fund and allocated to insurers after simple risk adjustment
Supplemental insurance	Allowed; has risk-rated premiums; cannot cover cost sharing for basic package About 90% of the insured population had supplemental coverage in 2009	Allowed; has risk-rated premiums; cannot cover cost sharing for basic package About 90% of the insured population had supplemental coverage in 2007
Main information on insurers and providers	Provided by government; the website http://Kiesbeter.nl includes information on insurers and providers; information on quality of insurers and providers is limited	Provided by private sources; the website http://comparis.ch includes information on insurers but not providers; information on quality of insurers is very limited
Selective contracting with providers	Allowed; used marginally by some insurers	Not allowed (except in managed care programs)

SOURCES Organization for Economic Cooperation and Development and World Health Organization, OECD reviews of health systems (Note 7 in text); Van de Ven WPMM et al., Evaluatie Zorgverzekeringswet en Wet op de zorgtoeslag (Note 17 in text). **NOTES** As of 2011 the Netherlands had 16.7 million inhabitants, and Switzerland had 7.9 million. CHF is Swiss francs. [a]In 2010 the lowest median premium by cantons was 75 percent of the highest median premium.

be community rated within cantons, so every resident of a canton who buys a particular insurer's plan pays the same premium. However, the insurer can charge different premiums for the same plan in other cantons. Premium adjustments are permitted only for three age categories (Exhibit 1). These requirements lead to substantial variation in premiums across cantons because of differences in population health risks and provider costs among the cantons.[4]

It is noteworthy that premiums for the same basic plans also vary greatly within cantons—an outcome that would not be expected in a competitive market. The premium differences within cantons reflect the expected costs of each insurer's enrollees in each plan, even though people are permitted to switch plans as often as twice a year. However, the rates at which people switch plans have been relatively low—only 3–5 percent per year (Exhibit 2).[7]

Because the basic plans do not cover dental care and some other services, almost 90 percent of the insured population purchases supplemental insurance (Exhibit 1).[7,8] In contrast to the basic plans, with supplemental policies insurers may reject an applicant for coverage and can rate premiums based on risk.

One explanation for why few people change their basic plans is that they are overwhelmed by the number of plan choices.[9] Another is that people fear that their supplemental plan premium could skyrocket if they have health problems but do not have the same insurer for both basic and supplemental plans.[10]

Thus, although the Swiss have many choices of insurers and plans, there are still substantial differences in premiums for the same standardized plan within cantons. Moreover, health care costs have continued to rise (Exhibit 3), reflecting the fact that Switzerland's health reforms to

EXHIBIT 2

Key Characteristics Of Health Insurance Markets In The Netherlands And Switzerland

	Netherlands	Switzerland
Risk-adjustment system	A central fund allocates pooled income-related contributions and government contributions to insurers based on the risk profile of the insurers' enrollees	A central fund allocates premiums to insurers based on the risk profile of the insurers' enrollees; risk adjustment is performed separately in each canton and is budget-neutral
Risk adjusters	Age, sex, pharmacy cost groups, diagnostic cost groups, employment status, and region; socioeconomic status	Age, sex, and prior hospitalization; plans are to add morbidity-based adjusters to reduce inequities
For-profit insurers	Allowed for basic and supplemental policies; only one of the four largest insurers is for-profit	Not allowed for basic policy; allowed for supplemental policies
Tax subsidies	Maximum per month of $115 (€88) for single people, $224 (€172) for couples; 60% of households received a subsidy in 2011	National average $1,665 (CHF 1,571), varying across cantons from $706 to $2,696 (CHF 666–2,543); about 30% of insured people received a subsidy (administered by cantons) in 2009
Deductibles	$456–$1,108 (€350–€850) per year; excludes primary and maternity care	$318–$2,650 (CHF 300–2,500) per adult
Cost sharing	Copayment required for some pharmaceuticals, but at least one drug always available without copayment	10 percent of provider costs above the deductible, up to an annual maximum of $742 (CHF 700) per adult and $371 (CHF 350) per child
Group contracts	Individuals can obtain a discount of up to 10% as a member of a group; groups include labor unions, sports and patients' associations, employer groups	Not allowed
Insurance market concentration	14 major insurers (some of which have subsidiaries with different names, leading to a slightly larger number of insurers), from which every person can purchase coverage Five largest insurers cover 94% of the population (high level of concentration)	81 insurers (including many small subsidiaries of some large insurers); average person has a choice of 59 insurers Five largest insurers cover 43% of the population (modest level of concentration)
Rate of switching among plans	About 18% in the first year after the 2006 reform; 3.5–6% in 2007–12	3–5% (estimated) in 1997–2008; rate seems to have increased since 2008 because of premium increases

SOURCES Organization for Economic Cooperation and Development and World Health Organization, OECD reviews of health systems (Note 7 in text); Vektis, Zorgthermometer (Note 11 in text). **NOTE** CHF is Swiss francs.

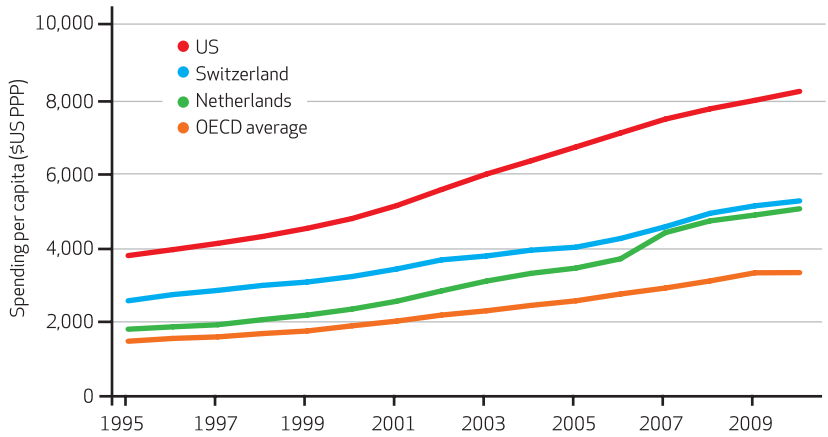
date have focused only on insurance markets. The Swiss are currently contemplating reforms involving the purchasing market, with the aim of slowing increases in health costs.

DUTCH REFORMS In 2006 the Netherlands launched a market for private insurance, following almost two decades of preparation for managed competition in health insurance. People are required to purchase insurance policies, and insurers must accept all applicants. Insurers must sell basic policies that cover a comprehensive set of benefits for acute care.

Premiums for basic plans for acute care are lower for policies with higher deductibles, but only about 7 percent of the population has chosen a higher-deductible plan.[11] People can switch plans at the beginning of each calendar year. However, except for 2006–07, when the insurance market was launched, the rates at which people have switched plans have been low. For the period 2007–12 the rate was 3.5–4.4 percent (Exhibit 2).[12] The most recent

EXHIBIT 3

Per Capita Health Care Spending, Selected Countries, 1995–2010



SOURCE Organization for Economic Cooperation and Development. StatExtracts: health expenditure and financing [Internet]. Paris: OECD; [cited 2013 Mar 4]. Available from: http://stats.oecd.org/Index.aspx?DataSetCode=SHA **NOTE** PPP is purchasing power parity.

estimates show a rate of 6 percent in 2012.[11]

Unlike Switzerland, the Netherlands permits people to buy insurance as members of a group (Exhibit 2), and 68 percent of people do so.[11] To date there is no evidence that insurers are using group contracts to "cherry-pick" less expensive enrollees, but the existence of identifiable subpopulations such as people in a sports club raises concerns about future risk selection.[13]

Insurers in the Netherlands are clearly engaged in robust competition, resulting in relatively uniform premiums for the same plans.[4] However, health care costs increased sharply in 2007 and have continued to rise (Exhibit 3). One explanation for this trend is that insurers have limited ability or interest to pressure providers to reduce their costs because the government controls most payments to providers.

Although reforms are under consideration that will strengthen the system, there remains a lack of managed competition in the purchasing market. The competitive nature of the Swiss and Dutch insurance markets differs. The Dutch market shows robust premium competition even though 94 percent of the population is insured by the five largest insurers (Exhibit 2). In contrast, the Swiss market has substantial variation in premiums even though the market is much less concentrated. The differences suggest that how markets are regulated is critically important for the success of incentives to increase market efficiency.

Lessons On The Design And Operation Of Health Exchanges

MAKE RISK-ADJUSTMENT MODELS SOPHISTICATED AND UPDATE THEM A health insurance market operating under managed competition requires a risk-adjustment system that minimizes insurers' incentives to avoid enrolling people whose expected health costs will exceed the premium and contribution payments they will make.[1]

A simple explanation for the different market outcomes in the Netherlands and Switzerland is that the Dutch have a relatively sophisticated risk-adjustment model and the Swiss do not (Exhibit 2).[14] Swiss policy makers originally assumed that people would switch from more expensive plans to cheaper ones, gradually producing balanced risk pools among insurers' plans. Thus, a complex risk-adjustment formula did not seem necessary. But many people have not changed insurers, and analyses indicate that Swiss insurers have engaged in risk selection.[15,16]

In contrast, the Netherlands has been experimenting with its risk-adjustment formula, revising it and gradually adding risk adjusters—factors to adjust for differences in risk among patients—for more than twenty years. Even so, the Dutch have worried, especially since the 2006 reforms were implemented, about the potential for insurers to risk-select.[13,17]

For example, if the risk-adjustment factors for some medical conditions are generous, insurers may respond by figuring out how to provide care efficiently to people with those conditions. Dutch people with chronic conditions such as diabetes are permitted to form groups for the purpose of obtaining premium discounts, and some have already done so. Thus, between risk-adjustment factors for some conditions and group contract discounts, insurers have incentives to provide care more efficiently to some people.

Insurers also can more easily engage in risk selection for basic plans when they are permitted to sell supplemental policies that can have risk-rated premiums (unlike the basic plans' premiums, which are community rated). In both countries, most people with supplemental coverage obtain it from their basic-plan insurer. Recent analyses suggest that insurers risk-select by setting low premiums for supplemental policies for people they expect will be profitable to insure with both basic and supplemental plans.[18]

DETERMINE WHY PEOPLE DO NOT ENROLL, AND RESPOND It took Switzerland and the Netherlands a while to realize that some people, especially those eligible for subsidies, had not chosen a health plan. As people in both countries became responsible for selecting a plan and paying a monthly premium, and as premiums increased because health care costs continued to rise, the number of uninsured people—those who choose not to enroll—increased. At the same time, the number of insured people who defaulted on their premium obligations also rose.

The Swiss federal government reacted in 2006 by allowing insurers to suspend people's coverage until they paid their outstanding premiums. Yet the number of premium defaulters continued to grow, reaching 4.3 percent of the population in some cantons.[19]

Subsequent analyses showed that a majority of defaulters had insufficient incomes to pay the premiums, but their incomes had been incorrectly estimated to be so high that they were ineligible for subsidies. After three years of debate, in January 2012 cantons began paying insurers 85 percent of unpaid premiums on behalf of people with serious financial problems.[19]

The Netherlands also has been challenged by the failure of some people to choose a plan or by their defaulting on premium payments. The 2006 law called for uninsured people to pay fines and permitted insurers to disenroll people who

failed to pay premiums for six months. In spite of these sanctions, in 2009 the share of premium defaulters rose to almost 2 percent of the population,[20,21] and some 60 percent of the defaulters in that year were receiving premium subsidies.[22] The continuing growth in health costs and premiums, compounded by stagnant incomes due to the recession, probably caused the jump in numbers of defaulters.

The Dutch government subsequently shifted its approach to the uninsured and defaulters. Since 2011 it has been attempting to identify the uninsured, and premiums are now automatically deducted from defaulters' salaries. Insurers may no longer suspend defaulters' coverage.

MAKE PREMIUM SUBSIDIES SIMPLE TO ADMINISTER, EASY TO APPLY FOR, AND DIFFICULT TO ABUSE In the Netherlands a person's subsidy is based on his or her final tax assessment for the previous year. People can apply for a subsidy via the Dutch Tax Office, using a relatively simple process.

The subsidy is provided each month as an advance payment, with an annual maximum on the amount that a person can receive. The Dutch also have made it easy for people to use the Tax Office website to file any change in income or family size, whereupon the subsidy amount is adjusted. Any difference between the total advance payments and the current year's final entitlement is settled when the current year's tax assessment is finalized. If people become defaulters, the Tax Office sends the subsidy payments to the insurer instead.

In Switzerland some cantons inform households automatically about their eligibility for a subsidy, while other cantons wait for people to apply for it.[7] Cantons also differ in income and asset eligibility criteria for subsidies and in how they calculate a household's subsidy.

Such differences created disparities in subsidy amounts that, together with rising premiums, have led to defaulting by lower-income people (as described above). In 2010 the federal law was amended to require cantons to guarantee premium payments to insurers for people who could not pay. Subsidies now are sent directly to insurers.

Lessons On Containing Health Cost Growth

INTERIM STEPS NEEDED TO GUIDE INSURERS In both Switzerland and the Netherlands, creating insurance markets with managed competition was expected to produce stronger insurers that could pressure providers to be efficient and thereby slow the growth in health care spending. Like almost every other European country, Switzerland and the Netherlands have long histories of government-determined prices and budgets for health services.

With their 2006 reforms, the Dutch loosened restrictions on negotiations between insurers and hospitals with respect to volume, price, and quality of services. As a result, insurers may now engage in selective contracting with hospitals. Prices for most general practitioners' services remain strictly regulated.

However, it is becoming increasingly clear that insurers have neither sufficient knowledge about hospital costs and quality of care nor enough experience to negotiate effectively with hospitals.[23] Negotiations over hospital payments still take place within the framework of a national global budget and have centered on volume of services rather than price and quality of care.[24] In an attempt to improve insurer-hospital negotiations, the Dutch government simplified the diagnosis-related group type of payment system in 2012 by reducing the number of groups from 30,000 to about 4,400.

Until quite recently, insurers hesitated to use selective contracting with hospitals. They were concerned about public backlash if they went against the societal expectation that everyone will have access to hospitals close to home. However, at least two insurers have started selectively contracting for specific hospital services; CZ began to do so in 2010, and Menzis, in 2012.

In addition, in February 2013 Achmea—the largest of the Dutch insurers, with about five million enrollees—announced that it would not contract with a major hospital in Amsterdam because of a dispute over the hospital's budget.[25] A recent national agreement, in force until 2015, limits hospitals' budgets to a 5 percent annual increase, of which 2.5 percent is for inflation. Achmea had offered a contract with a 5 percent increase in budget, inflation included, compared to 2012, but the hospital wanted a larger increase.

Thus, some insurers are already pressuring hospitals. However, the negotiations have to do with national budget goals rather than efforts to increase efficiency in the delivery of care.

In the decentralized Swiss system, prices of inpatient services are mostly negotiated between insurer associations and hospital associations in each canton. Insurers cannot independently negotiate payment rates, even though the hospital sector is a major driver of health costs.[7]

In both countries, standardized data about different hospitals' costs and quality of care need to be developed, and insurers need to acquire expertise in negotiating before they can be prudent purchasers of health care. These efforts require

time and a determination to establish a balance in bargaining power between insurers and providers.

Until these conditions for a competitive purchasing market are in place, interim efforts are needed to control the growth in health costs. Global budgets and price regulation continue to play an important role in the Netherlands and Switzerland as both countries explore developments in managed care, bundled payments, pay-for-performance, and coordinated delivery systems.

USEFUL, RELIABLE INFORMATION IS NEEDED

Switzerland and the Netherlands have discovered that reforms of their health care provision markets require that patients and insurers be provided with better information about providers. In both countries good information about providers' quality of care and relative costs is still hard to find.

In Switzerland the existence of highly autonomous cantons complicates the process of collecting and presenting consistent data about providers. Efforts to introduce nationally consistent measurements of provider costs and quality-of-care indicators are under way, albeit only for hospitals.[7] And even when information about health plans or providers is available, it is frequently difficult for consumers to understand and use.[26]

Implications For The United States

In the United States the design and implementation of exchanges under the Affordable Care Act are entering a critical stage. States and the federal government are making decisions that will determine how well the exchanges will work in expanding health insurance coverage and creating price competition among insurers.

The recent Swiss and Dutch experiences with creating insurance markets show the complexity of achieving desired outcomes with managed competition. Even so, these experiences have clear implications for US policy makers engaged in the planning needed to achieve high enrollment rates and efficiency under the Affordable Care Act exchanges. We offer five lessons for the new exchanges.

First, sophisticated risk-adjustment mechanisms are necessary, and regular revisions of the risk-adjustment formula are crucial. If the formula does not keep pace with what insurers learn to do more efficiently, such as manage the care of people with conditions for which there is a risk-adjustment factor, or with market-driven changes, then insurers will have an incentive to risk-select.

Periodic revisions make it easier to incorporate new data if there is evidence of risk selection. Moreover, revisions act as a signal to insurers that investing in risk selection will not be profitable in the long term.

Second, threats of tax penalties or fines for people who do not obtain health insurance are unlikely to achieve universal coverage. States should be prepared to spend resources to determine why people do not obtain coverage and to craft responses that will help people enroll in a plan.

Third, the Swiss and Dutch experiences underscore the importance of both informing people that they are eligible for subsidies and making the application process simple. US states will need to make it easy for people to notify Medicaid or the exchanges when they have changes in income or family size during a particular year so that abuses of the subsidies do not occur.

Fourth, insurers cannot be expected to negotiate aggressively with providers, especially hospitals, over costs and quality of care unless they have bargaining power similar to that of providers. Insurers that sell policies in the exchanges may gain some market share, but it will not be sufficient to justify expectations that exchanges can help contain costs. It is likely that other measures will be needed to generate incentives for efficiency and cost containment.

Toward that end, the fifth lesson is that meaningful and reliable information about providers' costs and quality of care will have to be developed and become available before insurers and consumers can be prudent purchasers of care. The experiences in the Netherlands and Switzerland suggest that doing so will not be an easy task. The current trend in developing quality measures based on health outcomes is an important step toward informing consumers and insurers about the performance of providers.

Until such information exists, we should examine how the provider organizations that are now forming in response to cost pressures from Medicare, employers, and some insurers perform in producing greater efficiencies and containing costs. Accountable care organizations and enlarged networks that include a variety of providers, such as academic hospitals, community hospitals, and home health agencies, may offer indications of where efficiencies might be found as they respond to payer cost pressures.

Conclusion

The political and legal battles surrounding the Affordable Care Act are a reminder that health reforms are subject to compromise. Implementation of legislation invariably causes reforms to

evolve as circumstances change.

Switzerland and the Netherlands have experienced political changes since their health reforms were initiated, but policy makers in those countries have continued to work toward improving managed competition in their health markets and dealing with unintended effects of reform.[27] Similarly, American policy makers will need to conduct ongoing analyses of the different state exchanges and the federal exchange to learn what works best to create incentives for efficiency. ■

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By Wilm Quentin, David Scheller-Kreinsen, Miriam Blümel, Alexander Geissler, and Reinhard Busse

Hospital Payment Based On Diagnosis-Related Groups Differs In Europe And Holds Lessons For The United States

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ABSTRACT **England, France, Germany, the Netherlands, and Sweden spend less as a share of gross domestic product on hospital care than the United States while delivering high-quality services. All five European countries have hospital payment systems based on diagnosis-related groups (DRGs) that classify patients of similar clinical characteristics and comparable costs. Inspired by Medicare's inpatient prospective payment system, which originated the use of DRGs, European DRG systems have implemented different design options and are generally more detailed than Medicare's system, to better distinguish among patients with less and more complex conditions. Incentives to treat more cases are often counterbalanced by volume ceilings in European DRG systems. European payments are usually broader in scope than those in the United States, including physician salaries and readmissions. These European systems, discussed in more detail in the article, suggest potential innovations for reforming DRG-based hospital payment in the United States.**

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European countries often look to the United States for inspiration and innovation in ways of organizing and paying for health care. One prominent example of US innovation was the Medicare inpatient prospective payment system introduced in 1983 in the United States.

The basic idea of the system was to classify hospital cases into diagnosis-related groups (DRGs) of patients with similar clinical characteristics and comparable costs, and to pay hospitals a flat fee for each DRG that reflected national average treatment costs of patients in that grouping. At the time, this idea was revolutionary, and it was adopted by countries around the world. Consequently, DRG-based hospital payment systems gradually emerged as the principal means of paying for hospital care in most developed countries,[1] particularly in Europe.[2]

The United States has now embarked on another quest to identify innovative payment models that will contribute to better health care at lower costs. The recently established Center for Medicare and Medicaid Innovation, a branch of the Department of Health and Human Services, is a primary player in that pursuit. However, US payment reform efforts might also benefit from a look at how payment systems originally inspired by Medicare have developed abroad.

European countries such as England, France, Germany, the Netherlands, and Sweden spend less on hospital care than the United States, both per capita and as a percentage of gross domestic product (GDP) (see Exhibit A1 in the online Appendix).[3–5] At the same time, these countries deliver high-quality care in hospitals. They score similarly to the United States on a long list of quality indicators, and most of them do not have waiting times for care that are any longer than in the United States.[6,7]

We analyzed hospital payment systems in

Europe based on a conceptual framework that was originally developed by Randall Ellis and Mark Miller,[8] which we expanded for our purposes. We used this framework to highlight differences between European hospital payment systems and Medicare's inpatient prospective payment system. In doing so, we summarized the results of EuroDRG, a large European research project comparing DRG-based hospital payment systems in Europe.

The framework by Ellis and Miller highlights the principles underlying different provider payment mechanisms and facilitates an understanding of how countries pay for hospital services. It consists of five dimensions for analysis that apply to all payment systems: the basis of information for determining hospital payments; the scope of payments; the adequacy of payments; the fineness of payments, or whether a system reflects different levels of severity in patient illnesses; and quality, or whether the payment system provides incentives for delivering high-quality health care services.

European DRG-Based Hospital Payment Systems

It is unlikely that any hospital payment system will ever be able to align perfectly the interests of payers, patients, and providers.[9] We do not pretend that the features of hospital payment systems in England, France, Germany, the Netherlands, and Sweden necessarily make those systems better than Medicare's inpatient prospective payment system. However, we believe that numerous features and innovations of European hospital payment systems can serve as models of better ways of paying for hospital care in the United States.

In England, France, Germany, the Netherlands, and Sweden DRG-based hospital payment systems were introduced between 1995 and 2005—one or two decades after the introduction of the Medicare inpatient prospective payment system (Exhibit 1). In Europe the dominant provider payment mechanisms prior to the introduction of DRGs were systems of global budgets or spending limits, with adjustments for activity—for example, in terms of

EXHIBIT 1

Basic Characteristics Of Diagnosis-Related Group (DRG)–Based Hospital Payment In 5 European Countries And The United States, With Basis Of Information For Payments

	England	France	Germany	Netherlands	Sweden	US (IPPS)[a]
BASIC CHARACTERISTICS OF DRG-BASED HOSPITAL PAYMENT SYSTEMS						
Patient classification system	Healthcare Resource Group (HRG)	Groupe Homogène de Malades (GHM)	German DRG (G-DRG)	Diagnose Behandeling Combinaties (DBC)	NordDRG	Medicare severity DRG (MS-DRG)[a]
Year introduced	2003	1996	2003	2005	1995	1983
Prior payment system	Global budget (with activity adjustment)	Global budget (with activity adjustment)	Global budget (with activity adjustment)	Global budget (with activity adjustment)	Global budget (with activity adjustment)	Fee-for-service
Frequency of revisions	Annual	Annual	Annual	Irregular	Biennial	Annual
Applied to	All hospitals treating NHS in- and outpatients	All hospitals, in- and outpatients	All hospitals, in- and outpatients	All hospitals, in- and outpatients	Depending on county, in- and outpatients	All hospitals treating Medicare patients (some exceptions)
BASIS OF INFORMATION FOR PAYMENTS[b]						
Patient characteristics	Yes	Yes	Yes	Yes	Yes	Yes
Service characteristics	Yes	Yes	Yes	Yes	Yes	Yes
Provider characteristics						
Volume of activity (such as global budget)	No (but plans exist for volume cap)	No	DRG-based budgets	Budgets for 30% of DRGs	Volume ceilings or budgets	No
Location (such as market forces factor)	Yes	Yes	Yes	No	Yes	Yes

SOURCE Authors' own compilation based on Kobel et al. (Note 11 in text). Updated for the Netherlands based on Dutch Healthcare Authority. Introducing performance-based specialist medical care. Utrecht: The Authority; 2012. Dutch. **NOTES** IPPS is inpatient prospective payment system. NHS is National Health Service. [a]The DRG system used under the IPPS in the United States has changed names three times since 1983. From 1983 to 2000 it was known as the Health Care Financing Administration (HCFA)-DRG system. In 2001, as a result of the transformation of HCFA to the Centers for Medicare and Medicaid Services (CMS), HCFA-DRGs became CMS-DRGs. Finally, in fiscal year 2008 a substantially revised version of DRGs was launched under the name of Medicare Severity (MS)-DRGs. [b]For details, see Exhibit A2 in the Appendix (Note 5 in text).

number of patients, procedures, or total inpatient days.

The primary purpose of moving toward DRGs in Europe was to increase the transparency and productivity of hospitals.[10] For example, DRGs can increase transparency about hospitals' workloads by uncovering the fact that one hospital treats more complex cases than another—that is, that cases in one hospital fall, on average, into more costly DRGs than in another. DRGs can improve transparency about hospital resource use by exposing the fact that patients in the same DRGs are staying markedly longer (or are more costly) in one hospital than in another. Productivity is thought to increase because hospitals are paid on the basis of the number and types of patients treated, which provides incentives for them to treat a lot of patients while limiting the amount of resources used for treatment.

Today England and the Netherlands use DRG systems that they developed from scratch, while France, Germany, and Sweden have DRG systems that were originally imported from the United States or Australia and later adjusted to meet country-specific needs.[11] The DRG systems have all been revised several times since their introduction, and they show considerable heterogeneity in how individual patients are allocated into DRGs.[12–14]

We explain these different systems below, and we draw comparisons to the situation in the United States, where the DRG system has been revised annually and has changed names several times since 1983. In fiscal year 2008, following a very major restructuring of the grouping logic, Medicare's DRG system was renamed Medicare Severity-DRGs (MS-DRGs).

The DRG-based hospital payment system is the single most important payment mechanism in each of the five countries we studied. Approximately 60–85 percent of total hospital revenues flow through DRG-based hospital payment systems. These systems are the standard modality of paying for care at both public and private hospitals and cover both inpatients and day cases—patients formally admitted to the hospital for minor surgery who leave the hospital either the same day or within twenty-four hours.[15]

European DRG classification systems are applied to all patients, independent of their insurer or insurance status. Hospitals thus cannot shift costs to or fulfill their revenue expectations through patients with different payment modalities.

An important point is that in Europe, unlike in the United States, DRG-based payments often exist within a global budget that is usually set at the hospital level. There is no such overall budget for hospital inpatient payment under US Medicare. In addition, in Europe there may be separate global budgets for specific areas of care, such as mental health, and additional payments are available for certain services, such as treatment in intensive care units in England.

BASIS OF INFORMATION By way of background, payments of any type in health care can be defined based on provider, service, or patient characteristics or combinations of these. The basis of information for determining payments has an important influence on the incentives of the payment system.

For example, global budgets that are primarily based on provider characteristics, such as the number of available beds or types of specialties, ensure the availability of infrastructure but do not reward productivity, since those who provide more services will not be paid more for them. Fee-for-service systems, in contrast, encourage the provision of services but may lead to overprovision. Payment systems based on patient characteristics, such as diagnosis or age, provide incentives to treat a high number of patients while keeping costs per patient at a minimum.

All hospital payment systems based on DRGs take into account information about patient diagnoses, service characteristics (the particular procedures performed, such as heart or cancer surgeries), and other patient characteristics for a more balanced set of incentives.[16]

The basis of information for all DRG-based hospital payment systems in Europe is determined by the classification variables used for grouping patients into DRGs and by limits on the volume of activity, such as global budgets, and adjustment factors related to location or market forces. DRG systems in Europe rely mostly on patient and service characteristics that are also used in Medicare's MS-DRGs (Exhibit 1; also see Exhibit A2 in the Appendix for more details).[5,17]

However, in several European DRG-based payment systems, service characteristics play a more prominent role in the classification process. In England's Health Care Resource Groups, service characteristics are considered before patient characteristics such as diagnoses in the classification process.[11] In Germany the number of surgical DRGs has increased substantially since the introduction of the system in 2003.

Hospital payment in most countries depends on all three types of information—patient, provider, and service characteristics—as integral parts of the system. The excessive expansion of activity—a potential negative consequence of a strong link between service provision and payment received—is counterbalanced in Germany,

the Netherlands, and Sweden by the existence of provider-level targets or budgets that limit to a certain extent the revenues that hospitals can receive through DRG-based payments.

For example, in Germany the total volume of services that a hospital is targeted to provide is negotiated each year between sickness funds—entities fulfilling the role of insurer in the German system—and hospitals. If a hospital exceeds this target, the DRG-based payment is reduced by a certain percentage. The payment is increased if the hospital remains below the target. However, this mechanism did not stop the expansion of certain apparently more lucrative services such as hip implants,[18] because only the total volume of hospital services is limited, not specific activities.

SCOPE OF HOSPITAL PAYMENTS The scope of hospital payments refers to the level of aggregation or "bundling" of services in the DRG system—within providers or across providers and over time. Hospitals in most European countries receive one DRG-based payment for each admitted patient that covers all costs of services during a hospital stay, similar to Medicare's inpatient prospective payment system (Exhibit 2). However, unlike in that system, the scope of payments in European countries often extends beyond twenty-four hours after discharge.

For example, since 2004 hospitals in Germany receive only a single DRG-based payment that includes costs for readmission to hospitals for the same reason either within certain time limits defined per DRG or within thirty days after the initial admission. In Sweden, where county governments determine the modalities of DRG use, hospitals in Stockholm County do not receive a second payment for hip or knee replacement patients readmitted for complications from surgery within two years after discharge.

In addition, the scope of payment in Europe usually also includes physician salaries or fees. In most countries all services provided in hospitals by surgeons, anesthesiologists, radiologists, and others are covered by the DRG-based payment to the hospital, although exceptions exist in France and Germany (Exhibit 2).

In the Netherlands physician fees for care provided in the hospital have been included within hospital payments since the introduction of the Dutch system in 2008. Almost all countries include hospital capital costs within the DRG

EXHIBIT 2

Scope Of Hospital Payment In 5 European Diagnosis-Related Group (DRG)–Based Systems

	England	France	Germany	Netherlands	Sweden
Payments per hospital stay	One	One	One	Several possible	One
DRG extends until	30 days after discharge (for elective admissions)	30 days after admission or until upper outlier limit	30 days after admission or until upper outlier limit	42 days after discharge (for inpatient admission) or 42 days after outpatient treatment	Day of discharge (except in certain counties—for example, two years for certain groups of patients in Stockholm)
SCOPE OF PAYMENT INCLUDES:					
Recurrent costs	Yes	Yes	Yes	Yes	Yes
Physician fees	Yes	Yes—in public hospitals No—in private hospitals	Yes (except for 5% of cases treated by practice-based physicians)	Yes	Yes
Capital costs	Yes	Yes (but not all)	No (only some)	Yes	Yes
OUTSIDE THE SCOPE OF PAYMENT, ADDITIONAL PAYMENTS FOR:					
Specific high-cost services	Unbundled HRGs for chemotherapy, radiotherapy, high-cost drugs, and ICU care	Séances GHM for chemotherapy and radiotherapy; additional payments for emergency care, high-cost drugs, and ICU care	Supplementary payments for chemotherapy, radiotherapy, and high-cost drugs	Yes (since 2012) for ICU care, and provided in cooperation with practice-based physicians	Cost-outlier payments for cases above a threshold; additional payments for burns and high-cost drugs
Innovation-related payments	Yes	Yes	Yes	Yes (for expensive orphan drugs)	Yes

SOURCE Authors' own compilation based on Busse et al. (Note 2 in text). Updated for the Netherlands based on Dutch Healthcare Authority. Introducing performance-based specialist medical care. Utrecht: The Authority; 2012. Dutch. **NOTES** HRG is Healthcare Resource Group. ICU is intensive care unit. GHM is Groupe Homogène de Malades.

payment. The exception is Germany, where investment funding for hospitals is provided by the states. Consequently, the scope of hospital payment systems in many European countries is broader than in the United States.

The potentially negative consequences of a broader scope in hospital DRG payments, such as skimping on services that cannot be billed separately, are probably counterbalanced in Europe by additional payments for certain high-cost services. For example, in England, Germany, and France, chemotherapy, radiotherapy, renal dialysis, high-cost drugs, devices, and some other services are reimbursed separately through additional payments on top of the basic DRG-based payment. All systems have developed mechanisms to provide additional payments for certain innovative technologies, including drugs, when they are not adequately reimbursed through the payment system.[19]

ADEQUACY OF HOSPITAL PAYMENTS If DRG-based payments to hospitals are too low to cover treatment costs, providers will attempt to reduce costs by cutting services or reducing quality. If payments are too high, providers have no incentive to behave efficiently and will waste resources. In most European countries the size of payment per DRG is calculated by multiplying a payment rate or weight that is an indicator of the costs of care for patients in that DRG—higher weights for more costly DRGs—with a base payment or base rate that might vary depending on the location of the hospital to account for differences in production costs.

In most European countries DRG systems calculate weights differently than does the Centers for Medicare and Medicaid Services (CMS), the US agency that oversees the MS-DRG. CMS calculates weights on the basis of charges from Medicare claims and costs reported in hospitals' Medicare cost reports.[17] To calculate "cost-based" weights, CMS applies nationally uniform cost-to-charge ratios.

Exhibit 3 summarizes information about the collection of cost data used to determine hospital payment rates in Europe. England, France, Germany, the Netherlands, and Sweden collect data about costs of service provision in hospitals, but the size of the data sample and the quality of cost data vary among countries.

England mandates that all National Health Service (NHS) hospitals provide cost accounting

EXHIBIT 3

Adequacy Of Hospital Payment Rates And Fineness Of Categories Of Diagnosis-Related Groups (DRGs) In 5 European Systems

	England (HRG)	France (GHM)	Germany (G-DRG)	Netherlands (DBC)	Sweden (NordDRG)
COST DATA COLLECTION METHODOLOGY TO DETERMINE PAYMENT RATE					
Sample size (% of all hospitals)	All NHS hospitals	99 hospitals (5%)	253 hospitals (13%)	Resource use: all hospitals; unit costs: 15–25 hospitals (24%)	40 hospitals (45%)
Overhead cost allocation to departments	Direct	Step down	Step down (preferably)	Direct	Direct
Direct cost allocation	Top-down micro-costing	Top-down micro-costing	Bottom-up micro-costing	Bottom-up micro-costing	Bottom-up micro-costing
Time lag to cost data	3 years	2 years	2 years	2 years	2 years
FINENESS OF THE PATIENT CLASSIFICATION SYSTEMS					
Number of DRGs in 2010	1,404	2,296	1,200	Approx. 30,000 (reduced to 4,400 since 2012)	983
Number of DRGs in 2003 or at year of system introduction	610	598	664	Approx. 100,000 (2005)	722
Severity levels per base-DRG	≤3	4 (+1)	Unlimited	Not applicable	2
Assessment of CC	Chapter-specific CC lists	One global CC list with exclusions	PCCL	Not applicable (separate DBC)	One global list of SDs or procedures with exclusions

SOURCE Authors' own compilation based on Kobel et al. (Note 11 in text); Scheller-Kreinsen et al. (Note 19 in text); and Tan SS, Serdén L, Geissler A, van Ineveld M, Redekop K, Heugren M, et al. DRGs and cost accounting: which is driving which? In: Busse R, Geissler A, Quentin W, Wiley MM, editors. Diagnosis Related Groups in Europe: moving towards transparency, efficiency, and quality in hospitals. Maidenhead (UK): Open University Press; 2011. p. 59–74. Updated for the Netherlands based on Dutch Healthcare Authority. Introducing performance-based specialist medical care. Utrecht: The Authority; 2012. Dutch. **NOTES** Severity levels per base-DRG: All DRG systems have the possibility to subdivide basic categories (base-DRGs) into two or more final DRGs, each containing patients with a similar degree of severity or complexity. If a system has more DRGs per base-DRG—that is, more severity levels—patients within a DRG are, in theory, more similar regarding the level of severity. In France base-DRGs are subdivided into four severity levels. In addition, one "severity level" exists for short stays or outpatients, so severity levels are denoted as 4 (+1). HRG is Healthcare Resource Group. GHM is Groupe Homogène de Malades. G-DRG is German DRG. DBC is Diagnose Bechandeling Combinaties. NHS is National Health Service. CC is complication and comorbidity. PCCL is Patient Cumulative Complexity Level. SD is secondary diagnosis.

data to a national database—a requirement similar to the CMS requirement that hospitals treating Medicare patients submit an annual cost report. France, Germany, the Netherlands, and Sweden use data from only a sample of hospitals that follow a standardized cost accounting approach, employing a detailed bottom-up costing methodology to calculate costs of treating individual patients.

The time lag between collection of cost data and the use of this information for setting DRG payment rates differs across countries. The system in England relies on DRG weights based on cost data that are three years old, similar to the MS-DRG system in the United States, where weights are based on three-year-old cost data—although they are multiplied using two-year-old claims data. In the other four countries the time lag between collection of cost data and determination of payment rates is two years.[19]

There is a trade-off between collecting high-quality cost accounting information and ensuring that a large and representative sample of hospitals contribute to a national cost database.[20] The Netherlands has struck a balance between representativeness and data quality by collecting data on resource use from all hospitals and data on unit costs from a small sample of hospitals.[21]

Because collecting detailed cost accounting information requires additional work by hospitals, regulatory authorities in some countries have started to pay hospitals for participating in the cost accounting data sample. For example, in Germany hospitals receive a fixed allowance for participating in the cost data sample and a variable amount that depends on the number of patients, with high-quality cost data submitted to the database.[10]

One innovation related to the adequacy of payment to hospitals is the so-called best-practice tariffs in England. (The price schedule for DRGs is called the tariff schedule, so these tariffs are the rates that the NHS pays hospitals.) For certain high-volume DRGs, about which clear consensus exists regarding best practice—for example, hip fracture or stroke—hospital payments are no longer based on average costs but on costs of providing care that is in line with clinical guidelines.[22] Depending on the condition, payments to hospitals for best-practice tariffs may be above or below average costs of current care in hospitals. For example, for stroke care, guidelines request treatment on a stroke unit, brain imaging within specified time limits, and assessment for thrombolysis, and the best-practice tariff for hospitals complying with the guideline is set higher than average costs. In contrast, for primary hip and knee replacement, all hospitals receive a tariff that is below national average costs, with the rationale being that providers using enhanced recovery principles have lower costs.

FINENESS OF PAYMENTS In all payment systems, a "fine" hospital payment system is one with many different payment categories, whereas a "coarse" payment system incorporates only a few payment categories. For DRG-based systems, if the hospital payment system is not sufficiently fine to account for differences among patients, hospitals treating relatively sicker patients are not adequately reimbursed for their efforts. At the same time, hospitals treating patients with less complex conditions may be overpaid for their services.

In 2010 the number of DRGs in most European systems was higher than in Medicare's MS-DRG system. The number of DRGs ranged from 983 in Sweden to about 2,300 in France; the Netherlands was an extreme outlier with 4,400 as of 2012 (Exhibit 3).

Medicare's MS-DRG system, with 751 groups in 2013, has more groups than the older DRG system had, to better account for differences in the level of complications and comorbidities of treated patients. However, European countries, excepting Sweden until 2012, have increased the number of DRGs even more since 2003 to improve adjustments for severity of illness in their DRG systems.

In the German G-DRG system, the number of severity levels per basic category, base-DRG, is—in principal—not limited, and up to nine levels are now used. Thus, base-DRGs are subdivided into as many DRGs as is necessary to achieve relative homogeneity of resource consumption within each group. For example, base-DRG L63—infection of the urinary system—in the 2013 version of G-DRGs is subdivided into six DRGs according to the presence of very severe complications (yes/no), treatment of multidrug-resistant pathogens (yes/no), and age (<3 years, 3–5 years, >5 years).

To assess complication and comorbidity in the classification system, several European countries rely on a list that defines a specific complication and comorbidity level for every secondary diagnosis. An individual patient's severity level is determined by the secondary diagnosis with the highest complication and comorbidity level, while taking into account certain exclusion criteria that depend on primary diagnoses or procedures.

Some European countries have further developed this system, building on work done in Australia. For example, in Germany the G-DRG classification system calculates a patient cumulative complexity level on the basis of all relevant

secondary diagnoses, sex, and reason for discharge, such as leaving the hospital against medical advice.

HEALTH SERVICE QUALITY In Europe, England is the country that has taken the most systematic approach to incorporating quality into hospital payment. One mechanism for doing so is the Commissioning for Quality and Innovation payment framework, which allows local purchasers of hospital care to link a modest nationally fixed proportion of providers' income to the achievement of certain quality goals.[23]

In 2013–14 this proportion is set to 2.5 percent of the total financial volume of providers' contracts, with 0.5 percent being conditional upon achieving four nationally uniform quality goals and 2 percent to be linked to other realistic, locally agreed-upon goals. National goals could include improving dementia care and avoiding venous thromboembolism, while locally agreed goals could include reducing hospital-acquired infections, reducing the incidence of pressure ulcers, increasing the percentage of women having spontaneous vaginal delivery, and improving patients' satisfaction with hospital services.

Another mechanism for incorporating quality into payment is the best-practice tariffs, which may provide higher payments per case if hospitals adhere to agreed-upon standards. For example, for hip fracture surgery patients, quality standards mandate that patients receive surgery within thirty-six hours; be provided with multidisciplinary rehabilitation; and be screened for secondary prevention of complications, including falls and bone health assessment.

Other European countries rarely adjust DRG-based payments explicitly to provide incentives for higher quality performance. Most aim to ensure the provision of high-quality health services through other mechanisms, such as quality controls, minimum volume thresholds, and separate quality-related payments.

Lessons For The United States

The success of hospital payment reform in achieving better quality of care at a lower cost depends in part on factors that go beyond the design features of the payment system. European hospitals are embedded in a different institutional context than are US hospitals, and purchaser-provider relationships differ from one European country to another. The degree of integration of health care providers, the level of competition between providers, the ways of contracting with hospitals, negotiations for health care service volume limits, and mechanisms for monitoring providers' behavior and quality of care are determined by country-specific arrangements.

However, our analysis of hospital payment systems in five European countries suggests that experiences from Europe can inform hospital payment reform in the United States. For an overview of design options to improve hospital payment systems, and highlights of different examples of implemented options from Europe, see Exhibit 4.

European DRG-based hospital payment systems have a broader basis of information to set payment rates than Medicare's MS-DRGs have. The European DRG systems combine all three types of information—provider, service, and patient characteristics—to determine payment and provide a more balanced set of incentives. Several European DRG systems have a stronger orientation toward service characteristics than do MS-DRGs, which is further enhanced by additional payments for certain high-cost services.

This stronger orientation to patient characteristics is often counterbalanced by global revenue control measures for service delivery. Revenue constraint measures are not now part of Medicare's hospital payment system. However, the existence of DRG-based budget constraints and the use of volume adjusters to DRG-based tariffs in one state, Maryland, which uses DRGs as the basis of its all-payer system for hospital inpatient care, provide evidence of the potential for using such mechanisms in the United States to contribute to better cost control.[24]

Hospital payment systems in Europe are broader in scope than Medicare's MS-DRGs are. European systems incorporate more types of costs and longer time frames for services that extend several weeks after discharge. One DRG-based payment generally covers all services provided in hospitals, including physician salaries or fees.

In the United States almost 20 percent of Medicare beneficiaries discharged from hospitals are readmitted within thirty days,[25] mostly without ever having seen a physician after discharge. In most European countries hospitals would not receive a second DRG-based payment for readmissions within this period of time. Consequently, hospitals have strong incentives to improve their discharge arrangements. The United States is taking another tack to discourage readmissions. As of 2012 its Medicare program has begun penalizing hospitals that have readmission rates above certain thresholds for three conditions—heart attack, congestive heart failure, and pneumonia—and the penalty system will be expanded to more conditions over time.

In Germany a thirty-day readmission rule prevents hospitals, under certain conditions, from receiving a second payment for readmitted

EXHIBIT 4

Design Options To Improve Hospital Payment Systems, With Examples From Europe

Framework dimension	Design options to improve hospital payment (theory)	Examples from Europe
Information basis	Diversify the information basis: to provide a balanced set of incentives	England and Germany: stronger procedure orientation of DRG systems than in the US; add-on payments to reduce skimping incentives of DRG-based payments Germany, Netherlands, and Sweden: provider-level budgets or volume ceilings to balance incentives for expansion of activity
Scope of payment	Combine a broad scope of payment with add-on payments: to make providers responsible for all costs of care, including after discharge, and to encourage delivery of priority services	All countries (except Sweden): broad time scope: DRG payment includes readmissions within 30 days (or 42 days in the Netherlands) All countries: broad scope: physician salaries are included in DRG-based payments All countries: narrow scope: add-on payments for certain high-cost priority services on top of DRG-based payments
Adequacy of payment	Improve payment adequacy, so hospitals are adequately reimbursed for services they provide Pay hospitals on the basis of what it costs to deliver efficient and high-quality care, to reflect care in line with clinical guidelines	Germany, Netherlands, and Sweden: standardized bottom-up cost data collection in (a sample of) hospitals for reliable cost-weight calculation All countries (except England): two-year time lag between data collection and payment, to ensure that payments are in line with current practice (instead of three years as in the US). England: best-practice tariffs: encourage efficiency and quality by setting payments at costs of providing care in line with clinical guidelines (may be above or below average costs)
Fineness of payment	Improve the fineness of payment categories to enable better adjustment for severity of illness and adequate payments for specific DRGs	All countries (except Sweden): finer payment systems than in the US Germany: possibly better adjustment for severity of illness through calculation of Patient Cumulative Complexity Level
Quality	Link payment to quality to ensure value: when quality of care is measured, payments can be adjusted accordingly	England: CQUIN payment framework links 2.5% of provider contracts to achievement of a set of locally agreed quality measures England: best-practice tariffs for certain conditions: higher payments for providers if they adhere to agreed-upon quality standards

SOURCE Authors' own compilation. **NOTES** DRG is diagnosis-related group. CQUIN is Commissioning for Quality and Innovation.

patients. This rule contributed to a strong reduction in readmissions within 30 and 360 days after discharge since its introduction in 2004.[26] The broader scope of hospital payment in European countries resembles to a certain degree Medicare's Acute Care Episode Demonstration project,[27] and the experiences of European countries might encourage CMS to proceed in this direction.

In Germany, the Netherlands, and Sweden detailed and highly standardized bottom-up cost accounting information from a sample of hospitals is used to calculate adequate payment rates. Regulators in these countries do not need to worry about distortions that result from nationally uniform cost-to-charge ratios for the calculation of cost weights, such as those used by CMS.

European countries often use more recent data for cost weight calculation than CMS uses. In England the innovative approach known as best-practice tariffs[22] bases reimbursement for certain conditions on the costs of providing care that is in line with clinical guidelines, instead of average costs.

Adjustments for severity of illness in European DRG systems are possibly better than those in the United States, even though MS-DRGs represent an improvement over the earlier US DRG system.[28] In Europe it is more difficult for hospitals to specialize in profitable patients than in the United States. There is no simple relationship between the number of DRGs and the ability of DRG systems to explain variation in resource consumption.[29]

CMS could test whether certain European approaches to adjustment for severity of illness, such as the method of calculation of patients' cumulative complexity levels in Germany, can contribute to improved severity adjustment. If CMS were to start collecting standardized patient-level cost accounting data from hospitals, the agency would also be able to revise the MS-DRG system on the basis of higher-quality data. In Germany, where patient-level cost accounting data have been used to improve the system since its introduction in 2003, the ability of the system to explain variation in costs of care as measured

through reduction in cost variance has increased by more than 60 percent.[30,31]

In most European countries pay-for-quality initiatives are in the early stages of development. England is the only country that explicitly adjusts hospital payment for quality of care. The Commissioning for Quality and Innovation framework and best-practice tariffs are interesting developments.

Although the Commissioning for Quality and Innovation framework has not yet been evaluated, results of the Advancing Quality program, a program in the northwest region of England that preceded the national program, have recently been published.[32] Advancing Quality was organized as a tournament of participating hospitals and awarded large bonuses (up to 4 percent of the revenue for the associated activity) for improving or achieving goals in twenty-eight quality indicators covering five clinical areas (acute myocardial infarction, coronary artery bypass grafting, heart failure, hip and knee surgery, and pneumonia). The evaluation of the program found a larger reduction of mortality for the included conditions than for conditions that were not included and a larger reduction at participating hospitals when compared with other hospitals in England. The evaluation concluded that the program was associated with a clinically significant reduction in mortality. An early evaluation of the best-practice tariff for hip fracture has shown that the percentage of patients receiving care according to agreed-upon standards has increased considerably, from 24 percent in the first quarter of 2010 to 55 percent in the last quarter of 2011.[33]

Better data about quality of care in European hospitals should become available not only through improved coding of diagnoses and procedures but also through explicit quality measurement initiatives that go beyond routine documentation of diagnoses and procedures, such as the Commissioning Framework in England and the system of quality indicators elaborated in Germany.[34] With such data, European countries are bound to integrate this information in their hospital payment systems.

Conclusion

European countries often look to the United States for examples of ways to organize and pay for health care. One innovation that was successfully transferred, and that has fundamentally transformed hospital payment systems in Europe, is the Medicare inpatient prospective payment system. The United States could benefit likewise from taking into consideration experiences from Europe in adapting that system.

Hospital payment systems in England, France, Germany, the Netherlands, and Sweden provide examples of ways to draw on a more diversified basis of information to determine payment, incorporate a broader scope that extends until several weeks after discharge, result in payments that more adequately reflect the cost of services, and have better adjustments for the severity of illness. These system features could provide further inspiration for hospital payment reforms already under way in the United States. ■

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In this month's *Health Affairs*, Wilm Quentin and coauthors describe how a number of European countries imported and expanded upon Medicare's inpatient prospective payment system, which originated the use of diagnosis-related groups, or DRGs. These countries evolved different design options that are generally more detailed than Medicare's system; have ceilings to limit the volume of care, unlike in Medicare; and are usually broader in scope, including physician salaries and readmissions. The authors propose that these European systems, discussed in more detail in the article, could suggest potential innovations for DRG-based hospital payment in the United States.

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ANALYSIS & COMMENTARY

State Insurance Exchanges Face Challenges In Offering Standardized Choices Alongside Innovative Value-Based Insurance

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ABSTRACT **Value-based insurance is a relatively new approach to health insurance in which financial barriers, such as copayments, are lowered for clinical services that are considered high value, while consumer cost sharing may be increased for services considered to be of uncertain value. Such plans are complex and do not easily fit into the simplified, consumer-friendly comparison tools that many state health insurance exchanges are formulating for use in 2014. Nevertheless some states and plans are attempting to strike the right balance between a streamlined health exchange shopping experience and innovative, albeit complex, benefit design that promotes value. For example, agencies administering exchanges in Vermont and Oregon are contemplating offering value-based insurance plans as an option in addition to a set of standardized plans. In the postreform environment, policy makers must find ways to present complex value-based insurance plans in a way that consumers and employers can more readily understand.**

Across the country, insurers are implementing a new benefit model called value-based insurance design. The goal is to make people healthier by reducing barriers to high-value services that have been shown to improve health, while at the same time generating savings by increasing consumer cost sharing for services that are deemed—based on available evidence—to be of uncertain value. Services and interventions that may be of uncertain value are often described as "preference sensitive" because for many patients the clinical benefits may not outweigh the high costs or risks associated with the intervention or service. High-value and preference-sensitive interventions are discussed in more detail below.

New value-based insurance models aim to shift consumers toward the most effective care and are frequently coupled with shared decision-making tools, such as instructional DVDs or informational websites, that help patients make treatment decisions that are aligned with their values, clinical needs, and goals. In many ways, value-based insurance design represents an effort to align patient incentives with new provider incentives to encourage better primary care, reward value of care over volume of care, and improve the treatment of chronic conditions.

Value-based insurance design is inherently more complex than traditional benefit designs, making it difficult for many consumers to understand. This complexity presents a conundrum for policy makers working to create the health insurance exchanges contemplated under the Affordable Care Act.

These online marketplaces are intended to make it easier for consumers to make informed choices about which health benefit plan to purchase. On the one hand, the Affordable Care Act

allows for benefit design flexibility and includes provisions to encourage insurers to promote quality improvement and greater efficiency. On the other hand, the act sets minimum standards for what benefits plans must provide and promises consumers the opportunity to make "apples-to-apples" comparisons among health plans sold through the health insurance exchanges.[1]

To ensure that consumers have access to a simplified health insurance shopping experience, a number of state exchanges have further standardized plans' cost sharing—or are considering it—so that consumers can easily compare deductibles, copayments, and coinsurance across each benefit category for each plan. Such requirements could constrain the expansion of value-based insurance design.

To evaluate this tension, we assessed current efforts to implement value-based insurance design programs and considered the obstacles and opportunities for these programs based on our review of the Affordable Care Act, accompanying regulations, public statements by federal and state policy makers, and interviews with state officials and insurance company representatives. We also reviewed state laws and early guidance to insurers regarding standards for participating in the health insurance exchanges. We conclude with considerations for policy makers attempting to balance standardization and innovation in benefit design.

Value-Based Insurance Design: State Of The Concept

Value-based insurance design is grounded in the notion that not all medical interventions are created equal—nor do they achieve equivalent results for all patients. Some interventions are high value, meaning that the clinical benefits outweigh the costs and risks. Some interventions are of uncertain value to many patients, meaning that the clinical benefits may not outweigh the high costs or risks associated with the intervention.

These interventions, where there is ambiguity about risks and outcomes, are often called preference-sensitive services because they may be right for some people but not for others, depending on their clinical status, individual goals, and preferences regarding the risks and benefits of their treatment options.[2] For example, a patient with chest pain caused by coronary artery disease may need to choose between invasive cardiac treatment and more conservative medical management. Similarly a patient with back pain may need to choose between surgery and physical therapy. In each case, the patient may be better served by the more conservative approach.

Traditional insurance design, in which consumers' cost sharing is the same regardless of the value of the service, has been found to lead to the underuse of high-value services and the overuse of preference-sensitive services.[3] Value-based insurance design attempts to realign those incentives by lowering or eliminating consumers' cost sharing for services that have been identified as high value in the clinical literature.

Value-based insurance design plans have been shown to increase enrollees' access to necessary care and improve patients' adherence to recommended treatments.[4] To reduce program costs, some value-based insurance plans also increase cost sharing for preference-sensitive services. Still other programs include a shared decision-making component, providing incentives for patients to use decision aids, such as instructional videos, printed materials, or even coaching from a designated care team member, to help guide them through treatment options based on their individual preferences and needs.

A national registry of value-based insurance design plans suggests that a substantial number of large employers and insurers have begun to implement value-based design in a variety of ways.[5] As an example, the Oregon Public Employees' Benefit Board and the Oregon Educators Benefit Board offer several value-based health plans. The Public Employees' Statewide Plan has no copayment for in-network chronic care office visits, preventive services, insulin, diabetic supplies, and certain "value" prescription drugs.[6] It also provides a free weight management program (Joan M. Kapowich, Oregon Public Employees' and Educators Benefit Boards, interview, September 4, 2012).

Enrollees in the Oregon plan, however, face higher cost sharing for several other services. In addition to in-network coinsurance of 15 percent, patients are responsible for a $100 copayment for certain imaging services, sleep studies, spinal injections, upper endoscopies, and emergency department use. Enrollees also face a $500 copayment for procedures such as knee arthroscopy and sinus surgery, which can be of variable appropriateness, depending on individual patient characteristics.[6]

Similarly, a value-based insurance plan pilot project in Colorado, called Engaged Benefit Design, waives cost sharing for several high-value items and services, such as primary care office visits; prescription medications; and supplies that help patients manage chronic conditions, such as asthma, congestive heart failure, depression, and diabetes. The plan also imposes an additional copayment for certain overused preference-sensitive services.[7]

Both the Oregon and Colorado programs rely on an independent advisory body that includes clinicians and consumer representatives to review current medical evidence and recommend items and services that merit either reduced or higher cost sharing. However, neither program offers a mechanism for assessing when a service assigned higher cost sharing might in fact be high value for a particular patient.

Although this deficiency could be problematic for some patients, an exemption process could lead providers to "game" the system so that all of their patients could qualify for lower cost sharing. In addition, enrollees might object if one person faces lower cost sharing than another for the same procedure.

Both the Oregon and Colorado programs attempt to mitigate concerns about higher cost sharing by encouraging shared decision making between patients and providers, so that patients have unbiased, appropriate information to use in weighing their options according to their values, needs, and goals. Because there is increasing evidence that better informed patients elect invasive treatments less frequently,[8] both programs encourage the use of patient decision aids.

For instance, the Colorado program offers patients a $50 gift card if they use a decision aid prescribed by their doctor. The decision aids, coupled with increased cost sharing for preference-sensitive services, are designed to fix financial incentives at a point that gives patients an incentive to consider their options more deeply, but not so high that patient cost sharing is an unreasonable barrier to access.

Value-based insurance design also acknowledges that not all providers are created equal; some provide high-quality, efficient care, while others are high cost, with little or no evidence that they provide better care. Thus, some value-based plans include provider tiering, a variant of the more common preferred provider network, in which patients face reduced cost sharing if they use in-network providers but higher cost sharing if they go out of network.

Provider tiering involves lowering cost sharing when patients see providers who perform well on cost or quality metrics and increasing cost sharing when patients see providers who do not perform well on such metrics. For example, Aetna offers Aexcel, a tiered network in which specialists are grouped into three tiers according to "case volume," "clinical performance," and "cost efficiency."[9] Similarly, Tufts Health Plan markets the "Your Choice" plan design, which groups hospitals, primary care providers, and specialists into three tiers based on their performance on cost and quality metrics.[10]

Value-based insurance design has its detractors. Concerns include a lack of agreement about what items and services merit higher cost sharing and what the "right" levels of increased cost sharing should be. In addition, critics cite a constantly evolving evidence base supporting—or discrediting—certain treatment interventions and the potential that some patients, particularly those with lower incomes who struggle to afford even small amounts of cost sharing, may face unreasonable financial barriers to accessing care they need.

Some plan sponsors also question how well value-based insurance design that incorporates shared decision making will work outside closed or contained provider networks, given the need for provider buy-in and education about the program (Ray Costantini, Providence Health and Services, interview, September 11, 2012).

In addition, some critics doubt whether patients in these programs can fully understand their cost-sharing obligations when they are making critical decisions about which providers to see and what care is right for them (Lynn Quincy, Consumers Union, interview, September 13, 2012). Explaining value-based benefit design also can be challenging for insurers and plan sponsors. A health plan executive noted in one of our interviews that communicating value-based insurance design to employees has been a top impediment to broader adoption among employers in the commercial insurance market (Ellen Dorrough, Providence Health Plan, interview, September 18, 2012).

Challenges And Opportunities

There are a number of challenges facing value-based insurance design in the post–health reform environment, as health plans and employers wrestle with a wide range of new standards and requirements, some of which could limit their flexibility to implement a value-based design program. To date, these types of plans have largely been the province of self-funded or large employer groups.[5] They have not yet been widely tested in the individual and small-group insurance markets.

There is also little experience with value-based insurance design in a program, such as Medicaid, that serves a low-income population that may be very sensitive to even small changes in cost sharing. As a result, we know little about how low-income people newly accessing coverage through the insurance exchanges would be affected by the variations in cost sharing inherent in a value-based benefit package.

In addition, the challenge of ensuring that a person shopping for a health plan understands how a value-based plan compares to other plans

is heightened as the number of health plan options grows. Consumers and employees shopping for coverage through an insurance exchange will have a much greater choice of plans than will most of those accessing a plan through their employer. There is considerable research suggesting that most consumers are confused by what is covered and what is not when they have more than one health plan option.[11] Researchers have found that consumers have particular difficulty understanding cost-sharing concepts such as deductibles, copayments, and coinsurance.[12] This confusion can too often cause consumers to make plan choices that are not right for their needs.[13]

At the same time, health reform also presents opportunities for innovative benefit design. Health insurance exchanges could expand opportunities for value-based insurance design by providing a new distribution model and better organizing insurance choices for consumers.

For example, one health insurer that has struggled to build a market for value-based insurance design, in part because employers find it too complex to explain to employees, believes there is a "real opportunity" for these plans in exchanges (Dorrough interview, September 18, 2012). If value-based insurance design can deliver better products for a better price, it is likely that consumers will gravitate to them.

Over the long term, by combining the purchasing power of small businesses and individual consumers, exchanges can be drivers of health system transformation, to the benefit of value-oriented insurance designs.[14] For instance, exchange officials could combine forces with other large health insurance purchasers in the state, such as the Medicaid agency, the state entity purchasing health benefits for public employees, or even a large private employer purchasing coalition to establish a common set of expectations and contracting requirements for health plans wishing to serve their enrollees. To the extent that the exchange and these other state purchasers agree that value-based insurance design is one mechanism for improving health outcomes and lowering costs, they could use their combined market clout to encourage or require more plans to include a value-based insurance design component.

Balancing Standardization With Innovation

Although the Affordable Care Act standardizes several elements of health insurance benefit design, it allows, and even encourages, insurers to offer value-based insurance plans. On the one hand, the law attempts to improve coverage adequacy and comparability through a minimum standard set of benefits called "essential health benefits" and a minimum level of coverage generosity, which is measured through a plan's actuarial value—a term denoting the percentage of the cost of covered benefits for which the plan pays. The law also requires insurers to display standardized information about their benefits and coverage.

On the other hand, the Affordable Care Act promotes value-based insurance design by requiring first-dollar coverage of evidence-based preventive services, meaning that patients face no cost sharing when they access these services. In implementing regulations, the Obama administration explicitly recognizes "the important role that value-based insurance design can play in promoting the use of appropriate preventive services."[15]

In implementing the law's essential health benefit standards and the actuarial value levels, the federal government has given insurers the flexibility to design products with many different combinations of deductibles, copayments, and coinsurance. The Department of Health and Human Services' proposed rule governing the essential health benefits suggests that insurers will be granted flexibility to adjust benefit design within each of the ten benefit categories, so long as any benefit changes are actuarially equivalent to the benchmark.[16] For health plans attempting to calculate actuarial value, the Department of Health and Human Services "recognize[s] the need to accommodate innovative plan design features...such as Value-Based Insurance Designs that vary the copayment or coinsurance for items and services based on expected value."[16]

The Obama administration has also shown flexibility in its policies regarding the new standardized forms that summarize the benefits and coverage provided in each available health plan to help consumers understand their policies. All plans are required to provide these summaries to consumers, along with coverage examples that demonstrate cost sharing for particular clinical scenarios. The summary form includes a table of copayments and coinsurance for doctor visits, drugs, and hospitalizations. The Department of Health and Human Services has said that the summary form will, for the first time, allow consumers to "easily compare different coverage options."[17]

However, federal regulators are permitting insurers with value-based or other unique benefit designs to deviate from the prescribed format when submitting these forms, so long as they apply their "best efforts" to describe their cost-sharing structure in a way that is "as consistent [with the form's requirements] as is reasonably

possible."[18] Such deviations could make it more difficult for consumers to compare their coverage options, contrary to the goals of the law.

State Efforts

State exchange leaders have pledged to make the health insurance purchasing experience easier, compared to a status quo that presents consumers with a dizzying array of options, often with no meaningful way to compare them. Of the eighteen states and the District of Columbia that applied to have a state-based exchange for 2014, the majority have websites or informational materials promising consumers a streamlined shopping experience that empowers them to make more informed plan choices. For example, Mississippi's website includes background materials describing an exchange as a "foundation in which those seeking insurance can easily compare plans and rates."[19]

States must square their promises for a simple, streamlined shopping experience with the inherent complexity of insurance plan design and the "choice overload" that consumers can experience when they are confronted with too many options.[20] In fact, many exchange administrators, regulators, and consumer advocates promote standardizing plans within each coverage level because it facilitates informed consumer choices, encourages insurers to compete on price, and reduces insurers' opportunities to use benefit design to "cherry-pick" healthier enrollees.[21]

As a result, a number of states are considering requiring greater standardization of benefits in their exchanges. Although this trend poses a potential threat to plans' efforts to vary cost sharing based on the relative clinical value of services, the states say they are also considering ways to accommodate innovative and value-based benefit designs.

For example, Massachusetts's exchange, called the Health Connector, has regularly adjusted the standardization required of participating insurers in response to consumer feedback and an evolving marketplace. When the Connector was first launched, in 2006, it used actuarial value to sort plan options. However, through market research, Connector staff found that asking consumers to rely on actuarial value to compare plans was like asking them to compare "apples to lava."[21] Consumers reported that they were confused by the range of benefit designs.

This response from consumers led the Connector board to standardize cost sharing. As a result, the number of product designs offered on the exchange decreased from thirty-six to nine between 2009 and 2010.[21] Although consumer feedback to standardization has been positive, for 2014 the Connector appears poised to offer additional plan designs that group providers into different cost-sharing tiers, based on their performance on cost and quality measures. Connector officials cite the need to offer products that have more "market appeal," particularly for small-business owners.[22]

Other state exchange planners are standardizing benefit design options. Oregon is requiring product standardization marketwide, both inside and outside its insurance exchange. In 2011 the legislature authorized state officials to "establish standardized, or cookie cutter, bronze and silver plans,"[23] referring to the Affordable Care Act's levels of coverage, with the bronze level being the least generous and the silver level signifying a more generous level of cost-sharing protection.

Insurers must comply with the standardization requirements to participate in the individual and small-group insurance markets, including the insurance exchange. Inside the exchange, insurers must offer a standardized plan at the bronze, silver, and gold coverage levels, with benefits and cost sharing determined by the Oregon Insurance Division. Insurers may also, at their option, offer two additional plans at each coverage level "that demonstrate innovation through the use of networks, wellness programs, or other options."[24]

State officials summarized their position this way: "These standardized plans should help purchasers make true apples-to-apples coverage comparisons and should eliminate 'cherry picking' of the healthier people through benefit design and cost sharing."[23] However, state officials have noted that insurers could offer a value-based product as one of their three plans in each tier.[25]

Section 100504 of the California Government Code gives the state's exchange permission to standardize benefit designs but does not require it, and Section 10112.27 of the California Insurance Code prohibits insurers from making substitutions within the essential health benefits package. Exchange officials have adopted a recommendation to standardize "major cost-sharing components of benefit plans" but will also allow insurers to submit one nonstandardized plan in addition to the standard plans.[26] In considering their options, exchange staff noted the importance of allowing the kind of innovation required by value-based insurance design and recommended allowing value-based designs that lower out-of-pocket expenses or provide financial rewards.[27]

In Vermont the agency responsible for administering the exchange has recommended that

the exchange balance standardization with innovation by offering a set of "state-specified" plan designs alongside some "choice" plans, to be designed by insurers "within set parameters." Agency officials note that such an approach will allow consumers to "make apples-to-apples comparisons when choosing their health coverage," while "carriers will have the opportunity to offer innovative choices."[28]

Rhode Island's Exchange Work Group studied the issue and noted that standardization will help consumers make smarter choices among health plan options but acknowledged: "Standardization is not without risks.... [I]f too restrictive, standardization could stifle innovation that promotes value." In particular, officials noted that value-based plans would be incompatible with product standardization.[29]

In these states, exchange planners recognize that too much flexibility in plan design can make it more difficult to fulfill promises that consumers will be able to make meaningful comparisons among plan options. At the same time, they also are supportive of offering value-based options to encourage consumers to obtain the high-value care they need. As a result, in designing their product offerings, they are often compromising by requiring a set of standardized plan offerings, coupled with the option for consumers to purchase a plan that varies from the standard.

Considerations For Exchange Planners

As exchange implementation moves forward, states can take additional steps to balance flexibility for value-based insurance plans with simplicity for consumers. In particular, a critical component in this balance will be the design of web-based health plan "chooser" tools.

How and what information is displayed to consumers via these tools will be of critical importance. If exchanges allow value-based insurance plans to be offered, their websites could be designed to enable consumers to compare cost sharing across plan options, understand the differences between a traditional plan design and a value-based design, and see how those differences could affect what they pay for care. Exchanges could also provide consumers with hypothetical clinical scenarios, mimicking the coverage examples already required under the Affordable Care Act, which model the cost sharing consumers might face if they have a particular condition, such as diabetes, heart disease, or low back pain.

Exchanges could also set clear design parameters for traditional and value-based products so that consumers can shop with confidence, knowing they are getting high-quality coverage that will not impose inappropriate barriers to necessary care. For example, exchanges could encourage or require the development of an exceptions process for value-based plans so that consumers are not financially penalized for obtaining care that is appropriate for their specific clinical needs.

In addition, as purchasers acting on behalf of individual consumers and small businesses, exchanges could work with insurers to encourage the use of shared decision-making tools to help consumers make treatment choices that align with their clinical needs, goals, and values. For example, exchange websites could include a symbol or flag to denote plans that encourage the use of patient decision aids.

Conclusion

Value-based insurance design offers a more nuanced alternative to traditional benefit plans, which often respond to premium increases by cost shifting to consumers through higher out-of-pocket costs for health care services across the board, without regard to the relative value of those services. However, value-based insurance design's inherent complexity can be challenging to explain to consumers and employers.

Furthermore, complexity can run at cross-purposes to health reform's vision of a reformed marketplace in which consumers are empowered to shop online and make "apples-to-apples" comparisons among plans. Nevertheless, early evidence suggests that many state policy makers are attempting a balance between a simple, streamlined shopping experience and the kind of benefit design innovation that promotes value. As they do so, they will need to pay critical attention to the new web-based tools consumers will use to help them understand and compare their health plan options.

At a minimum, transparency about benefits and cost sharing, and uniform definitions and descriptions of design attributes—in plain English—will be necessary to support informed consumer decision making. At the same time, state officials should consider ways the new health insurance exchanges, perhaps in conjunction with other health insurance purchasers in the state, can use their purchasing power to encourage the development of health plans that realign incentives to improve access to high-value primary care while also covering services appropriate for each person's clinical needs, preferences, and values. ■

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In this month's *Health Affairs*, Sabrina Corlette and coauthors discuss the challenges that state-based health insurance exchanges will face as they seek to offer standardized health plans to facilitate consumers' shopping experience. Exchanges also want to make available innovative health plan designs, such as value-based insurance. The latter type of policy lowers copayments for high-value clinical services, such as medication for chronic illness, and is gaining popularity among employers and insurers, which see the policies as a way to improve the quality of care while restraining cost growth.

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