Reports and Research

Table of Contents

June 20, 2013 Board Meeting

- *Private Coverage Under California's Affordable Care Act: Benefit and Cost-Sharing Requirements Affecting Children and Adolescents with Special Health Care Needs* – **Lucile Packard Foundation for Children's Health**
  May, 2013

- *HEALTH INSURANCE: Seven States' Actions to Establish Exchanges under the Patient Protection and Affordable Care Act* – **United States Government Accountability Office**
  April, 2013

Beyond Rebates: How Much Are Consumers Saving from the ACA's Medical Loss Ratio Provision?

Jun 06, 2013 | Cynthia Cox, Gary Claxton **and** Larry Levitt

Most of the conversation around the Affordable Care Act's Medical Loss Ratio (MLR) provision has centered on the requirement that insurers issue consumer rebates when they fall short of spending a certain portion of premium dollars on health care and quality improvement expenses. This makes sense as rebates are one of the more tangible ways consumers have benefited from the law so far, and it likely contributes to the MLR provision being among the more popular aspects of the health reform law.

However, as we've written before, rebates represent only a portion, albeit the most concrete portion, of the MLR rule's savings to consumers. The primary role of an MLR threshold is to encourage insurers to spend a certain percentage of premium dollars on health care and quality improvement expenses (80 percent in the individual and small group market and 85 percent in the large group market). The MLR rebate requirement operates as a backstop if insurers do not set premiums at a level where they would be paying out the minimally acceptable share of premiums back as benefits. Only if those thresholds are not met are insurers required to provide rebates to consumers or businesses. (You can read more about the MLR rule here).

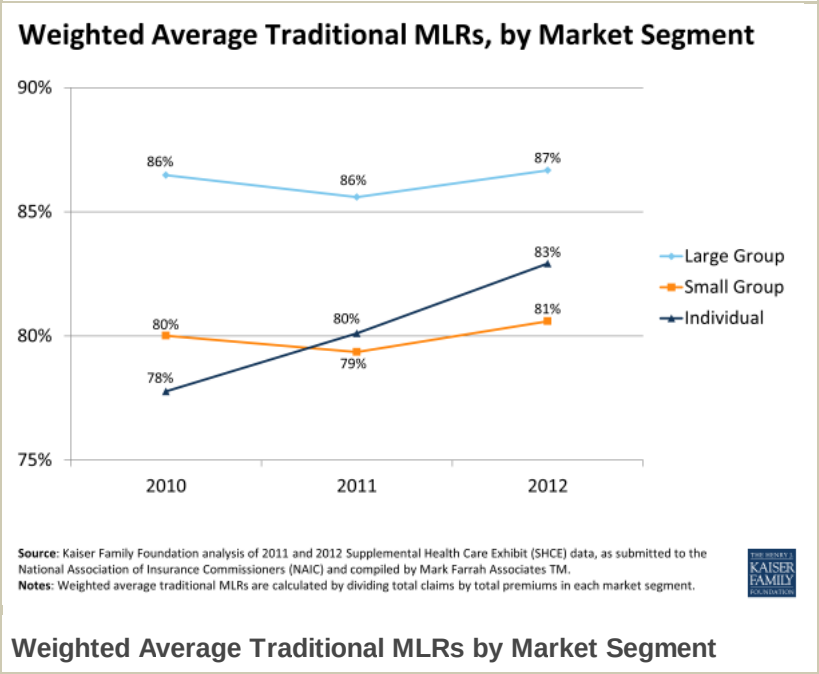
Consumers and businesses, therefore, can realize savings in two ways as a result of the MLR requirement: by paying lower premiums than they would have been charged otherwise (as a result of lower administrative costs and profits), or by receiving rebates after the fact. So while insurers paid out considerable amounts for rebates – last year's rebates totaled $1.1 billion – this is not the whole story for consumers.

Of course, it is hard to know with certainty what premiums would have been if the MLR rules were not in place: we cannot know for sure how insurers would have priced their products or what rates regulators would have allowed (to the extent that they reviewed rates prior to the ACA). It is also difficult to separate out the direct effects of the MLR provision from other aspects of the health reform law, particularly rate review, which works to moderate unreasonable premium increases and thus increase loss ratios. There are also data limitations. For example, prior to new reporting requirements put in place to enforce the MLR provision, there were not good data sources that break out premiums and claims on a consistent basis for major medical coverage by all types of carriers. In the initial years this data became available (2010 and 2011), there were some issues with the quality of the data, particularly regarding expenses for quality improvement and other new categories of administrative expenses that are reported on the exhibit.

Within these limitations, we constructed an analysis that looks at the basic proportion of premiums that health plans paid out as claims for medical care over the three years since the ACA was passed, both before and after the MLR requirement went into effect for coverage in 2011. These proportions do not include adjustments for quality improvement expenses, taxes or other factors that are used when determining whether or not rebates need to be paid; they simply represent the total payments for medical care as a proportion of premiums. This is the traditional way medical loss ratios have been calculated. Generally, if the proportion is rising, that means insurers are paying out more of each dollar they receive on enrollee health care, which in most cases would mean that enrollees are getting better value for the premiums they pay. We then quantify what the change in the traditional MLR means to enrollees by estimating how much they would have paid in premium if the observed MLR for 2010 (before the MLR requirement went into effect) were held constant for 2011 and 2012.[1] This approach addresses the following question: If insurers had targeted the same claims to premium ratio for 2011 and 2012 as they achieved in 2010, would premiums have been higher or lower, and by how much? In other words, it addresses how much consumers may have saved in lower premiums as a result of the MLR

threshold in addition to receiving rebates.

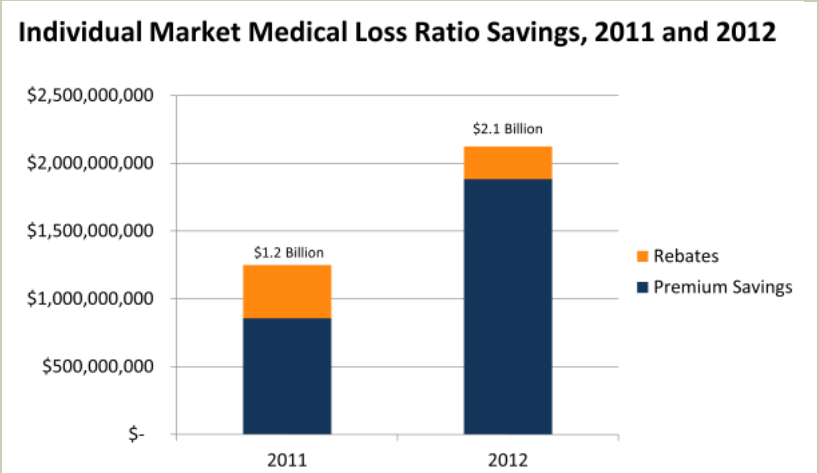
Our analysis uses insurer data filed to state regulators and compiled by Mark Farrah Associates. These data (filed on the Supplemental Health Care Exhibit) suggest that the main beneficiaries of the MLR rule's upfront premium savings are people who purchase insurance on their own. The majority of plans sold to small and large businesses were already in compliance with their respective MLR thresholds before the law went into effect, and our analysis shows that traditional MLRs (claims divided by premiums) for group plans have stayed relatively flat over the past three years. In the individual market, by contrast, fewer than half of plans were in compliance with the ACA's MLR thresholds in 2010, and the average traditional MLRs in this market have been steadily increasing since the requirement went into effect. This means that individual market insurers are devoting a greater portion of premium dollars to health care claims and less to administrative costs and profits compared to before the ACA's MLR rule went into effect.



Weighted Average Traditional MLRs by Market Segment

This pattern is consistent with the idea that some insurers needed to improve their MLRs to comply with the new rebate requirements. We know that the individual market MLR requirements in the ACA are higher than those that were in effect in many states, and there have been numerous reports that insurers worked to reduce their commissions and other administrative expenses to become more efficient.

So how might these changes have affected premiums? As noted above, one way to address this question is to compute what these consumers would have paid in premiums in 2011 and 2012 had traditional individual market MLRs stayed at 2010 levels (the year before the provision went into effect). Looked at this way, premiums would have been $856 million higher in 2011, and premiums would have been $1.9 billion higher in 2012.



Individual Market Medical Loss Ratio (MLR) Savings

Adding to the premium savings the amount individual market consumers received in rebates yields a total savings of $1.2 billion for 2011. This year, individual market insurers are expecting to issue $241 million in rebates (based on our analysis of early estimates from insurers filed with state insurance departments), bringing the total estimated savings for 2012 to $2.1 billion. While this savings was not distributed evenly (with more going to people enrolled in plans that had low MLRs prior to the law), when averaged across all individual market enrollees, this amounts to a savings of $204 per person ($181 in premium savings and $23 in rebates) in 2012. Taking into account both premium savings and estimated rebates, people purchasing insurance on their own in 2012 spent 7.5% less on average on insurance than they might otherwise have in the absence of the law.

There are some potential limitations to this approach. While the pattern of increasing MLRs over the three years makes sense given the incentives under the ACA and reports of insurer behavior, we do not have comparable data from earlier years to tell us whether or not the 2010 MLR was typical for the pre-ACA period (though the available evidence suggests that it was).[2] Also, MLRs in 2011 and 2012 might be overstated because insurers simply underestimated how much health care expenses would rise following the recession, though increasing MLRs still means that consumers have been getting better value for their premium dollars. Finally, rebate amounts for 2012 are based on preliminary estimates filed on the Supplemental Health Care Exhibit to state insurance departments, and actual rebate amounts will be based on insurer filings with the Department of Health and Human Services, which were due June 1.

If insurers' preliminary estimates hold true, this year's rebates (at a total of $571 million across all markets) are expected to be about half the amount of last year's $1.1 billion in insurer rebates. Smaller rebates, however, are not an indication that consumers are now saving less money as a result of the MLR provision, but rather that insurers are coming closer to meeting the ACA's MLR requirements and that this provision is having its intended effect of consumers getting more value for the money they spend on premiums. In fact, in the individual market, the $241 million consumers are expected to receive in rebates for 2012 represents roughly one tenth of our estimate of the overall savings from the provision in that year. Perhaps ironically, when the MLR provision is working as intended and insurers set premiums to meet the thresholds, consumers save money but are less likely to get a check in the mail as tangible demonstration of those savings.

Updated June 6, 2013 11:30 AM PT

Footnotes

/. See methodology attached

0, Based on our analysis of the Accident and Health Experience Exhibit submitted to state regulators, which has been required of all insurance entities since 2006 but is not directly comparable to newer and more precise data, the weighted average traditional loss ratio in 2010 was slightly higher (80%) than the average of previous years (79%). Our premium savings estimates for 2012 and 2011 are thus likely conservative compared with estimates that used MLRs in prior years.

ROBERT WOOD JOHNSON FOUNDATION
State Health Reform Assistance Network
Charting the Road to Coverage

Robert Wood Johnson Foundation

ISSUE BRIEF
June 2013

Impact of National Health Reform and State-Based Exchanges on the Level of Competition in the Nongroup Market

*Prepared by **Jon Kingsdale** and **Jason Aurori**, Wakely Consulting Group*

One of the objectives of the Affordable Care Act (ACA) reform of the nongroup insurance market, including new market and rating rules and reliance on public health insurance exchanges, is to enhance competition. More competing health plans increases consumer choice, as well as the market pressure on health plans to manage administrative costs, improve their service and contract with clinical providers at optimal rates. Especially in the context of health plans contracting selectively with providers in order to hold down payment rates, a choice of more health plans serves consumers well and signals a vibrant market. This brief provides an early indicator of the level of competition among health insurers that market reforms and state-based exchanges are generating.

While the concept of enhanced competition is multi-faceted and some competitive dynamics may elude quantification, one clear measure of the ACA's impact on competition in the nongroup market is the number of health plan issuers competing on exchanges. An early indicator should be the number of issuers which make a significant commitment to competing for nongroup enrollment, as measured by applications to participate on exchanges, compared to the number of carriers with a significant presence in the same nongroup markets prior to the reform. Given the considerable uncertainty among health plans over how the ACA will play out, as well as the significant effort required of them to apply to participate on exchanges, the number of issuers applying is a reasonably good indicator of how many issuers are seriously committed to competing for this market segment. As of mid-June, we now have such data for 10 state-based exchanges.

We focus on the nongroup market for two reasons: first, this is the market that reformers consider to have been most dysfunctional and therefore is most radically altered by the ACA; and second, because premium tax credits for individual coverage are tied exclusively to public exchanges, most issuers committed to the nongroup market will have to participate on exchanges. Public exchanges are expected to represent the bulk of nongroup enrollment.[1] By contrast, how much of the small-group market the Small Business Health Options Program (SHOP) exchanges will attract is unclear, and existing projections are modest. Therefore, issuer participation in SHOP probably does not equate to carrier participation in the small group market.

[1] Congressional Budget Office and the staff of the Joint Committee on Taxation, "CBO's March 2011 Baseline: Health Insurance Exchanges" projects nongroup enrollment in exchanges to be 3-to-6 times as large as group enrollment in exchanges, despite the fact that there are many more small-group than direct enrollees in total.

ABOUT STATE NETWORK
State Health Reform Assistance Network, a program of the Robert Wood Johnson Foundation, provides in-depth technical support to states to maximize coverage gains as they implement key provisions of the Affordable Care Act. The program is managed by the Woodrow Wilson School of Public and International Affairs at Princeton University. For more information, visit *www.statenetwork.org*.

ABOUT WAKELY CONSULTING GROUP
Wakely Consulting Group is an actuarial and healthcare consulting firm specializing in government healthcare programs including state and federal reform, Medicaid and Medicare Advantage. For more information, visit *www.wakely.com*.

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, measureable and timely change. For 40 years the Foundation has brought experience, commitment, and a rigorous, balanced approach to the problems that affect the health and health care of those it serves. When it comes to helping Americans lead healthier lives and get the care they need, the Foundation expects to make a difference in your lifetime. For more information, visit *www.rwjf.org*. Follow the Foundation on Twitter *www.rwjf.org/twitter* or Facebook *www.rwjf.org/facebook*.

For more information, please contact Jon Kingsdale at jonk@wakely.com or 617.939.2008.

Determining a baseline comparator for pre-reform competition entails some judgment calls. There are many carriers licensed across the country who do not have much presence anywhere, or may be licensed in some states where they make little effort to market locally. Indeed, so-called "shell licenses" for life companies—the licensure category for health, life, disability and other lines that are distinguished for property and casualty insurance—are often traded or sold for relatively modest consideration. So, a count of licensed entities in a state, many of which may have negligible enrollment, is not a credible indicator of the level of competition. Therefore, we assume that any issuer with (a) 3,000 or more covered lives or, (b) in small states, 5 percent of the state's total nongroup enrollment, is a significant competitor in that market. This threshold is very inclusive: it almost certainly includes some "marginal" players in the larger markets, such as California's multi-million member, nongroup sector.

While the number of issuers on state-based exchanges may grow or shrink over time—in Massachusetts, the number tripled in the first year of reform, from two to six competitors,[2] and has increased again by 50 percent since then—issuers which have applied for certification for 2014 will provide the earliest indication of the level of competition post-reform. For a pre-reform baseline, we use the number of carriers with a significant commitment to the nongroup market in these same states in 2011, except in Massachusetts. In Massachusetts, ACA-like reform was implemented in 2006, and an exchange for licensed commercial health plans began in 2007, so we use 2005 as the base year. For the relevant methodological assumptions, please see the section on "Methodology Assumptions" at the end of this brief.

The Centers for Medicare & Medicaid Services (CMS) has released some information on applicants to the federally facilitated exchange (FFE) that is expected to serve at least 33 states in 2014, but not a state-by-state count for individual enrollment, which would be needed to compare the number of competitors pre-reform with applicants for 2014. Seventeen states plus the District of Columbia have requested applications from issuers, but three of those states (Utah, Idaho and New Mexico) will rely on the FFE in 2014 to run their individual exchanges.

For the remaining 15 state-based exchanges, we took baseline data from Citi Research's state compendium of carriers and their enrollment in each market sector.[3] We were able to assemble from state announcements and websites, and confirm with state officials, the names of all applicants to participate as issuers of medical plans (excluding issuers of stand-alone dental plans only) on 10 nongroup exchanges. Five of the 15 state-based exchanges have not yet made all the requisite data publicly available. Thus, the data currently available for 10 state-based exchanges are summarized below.

Across the 10 states, the total number of carriers increased substantially, from 52 to 70, or by 35 percent. Six of the 10 states experienced an increase in the number of issuers applying to be on the nongroup exchange versus the number of significant competitors in the pre-reform, base year; and four states report no change. Among the six states reporting an increase of one or more in the number of competitors, the largest increase is for Massachusetts, which has seen an increase of seven health plans. California, Oregon and Washington each reported increases of three issuers.

How competition will evolve in most of these states is not yet known. However, there is reason to expect that in states where competition is now hardy, reform will encourage it to grow more intense. Massachusetts is the only state for which we have a measure of the long-term impact of reform on competition: not only have the number of competitors more than quadrupled over the seven years since reform, but market share is now far more evenly distributed as well. In the year before reform (2005), Blue Cross Blue Shield of Massachusetts (BCBSM) dominated this segment as the so-called "insurer of last resort," with an 80 percent share. In 2013 it has less than 40 percent of nongroup enrollment. And, with the restructuring of that state's exchange to comply with the ACA for 2014, five issuers are expected to have nearly as much or more nongroup enrollment as BCBSM.

[2] Report to the Massachusetts Legislature: Implementation of the Health Care Reform Law, Chapter 58, 2006-2008 (The Massachusetts Health Insurance Connector Authority: October 2, 2008), p. 28.

[3] McDonald, Carl, CFA. "A Good Lawyer Knows The Law, A Great Lawyer Knows The Judge - 2011 Commercial Risk Analysis" Citi Investment Research. January 28, 2013.

Summary of Results

	State	# of Issuers Pre-reform	# of Issuers Post-reform	Net Change
Increase	California	10	13	+3
	Colorado	9	10	+1
	Massachusetts	2	9	+7
	Oregon	9	12	+3
	Rhode Island	1	2	+1
	Washington	6	9	+3
Unchanged	Connecticut	4	4	0
	District of Columbia	3	3	0
	Maryland	6	6	0
	Vermont	2	2	0
Total		**52**	**70**	**+18**

Methodology Assumptions

For statewide nongroup markets with at least 100,000 enrollees in the base year, we use enrollment of 3,000 nongroup members as the minimum threshold for indicating that the carrier had made a significant commitment to competing in that market (many carriers are licensed in states where they have little enrollment or active presence). For nongroup markets with fewer than 100,000 enrollees, we use 5 percent share as the minimum threshold for counting a carrier (market share is based on enrollment).

Except for Massachusetts, the source of pre-reform figures is a report by Carl McDonald of Citi Research on commercial health insurance risk analysis, which cites the National Association of Insurance Commissioners (NAIC) and Citi Research.[4] Issuers listed under post-reform represent issuers that have applied to offer or will be offering qualified health plans on the nongroup exchange for the full set of required Essential Health Benefits (with the possible exception of dental benefits, which can be offered separately as stand-alone plans or in conjunction with the medical coverage).

[4] McDonald, Carl, CFA. "A Good Lawyer Knows The Law, A Great Lawyer Knows The Judge - 2011 Commercial Risk Analysis" Citi Investment Research. January 28, 2013.

Appendix: Results by State-Based Exchange

California

Pre-Reform (2011)		Issuers Accepted by the Exchange (2014) [5,6]
Total Issuers: 10		**Total Issuers: 13**
Issuer	**Market Share**	**Issuer**
WellPoint	47.1%	Alameda Alliance for Health
Blue Shield of California	20.8%	Anthem Blue Cross of California
Kaiser Permanente	19.0%	Blue Shield of California
Aetna, Inc.	5.2%	Chinese Community Health Plan
Health Net	3.3%	Contra Costa Health Services
HealthMarkets, Inc.	1.4%	Health Net
UnitedHealth Group	1.1%	Kaiser Permanente
CIGNA Corp.	0.7%	L.A. Care Health Plan
Assurant, Inc.	0.4%	Molina Healthcare, Inc.
New York Life Insurance Group	0.2%	Sharp Health Plan
		Valley Health Plan
		Ventura County Health Care Plan
		Western Health Advantage

Colorado

Pre-Reform (2011)[7]		Issuers Applying to the Exchange (2014) [8]
Total Issuers: 9		**Total Issuers: 10**
Issuer	**Market Share**	**Issuer**
WellPoint, Inc.	33.4%	All Savers Insurance Company
Humana, Inc.	11.1%	Anthem Blue Cross Blue Shield
Assurant, Inc.	10.7%	Cigna Health and Life Insurance Company
UnitedHealth Group, Inc.	10.1%	Colorado Choice Health Plans
Kaiser Foundation Health Plan of Colorado	9.9%	Colorado Health Insurance Cooperative, Inc.
Rocky Mountain Health Maintenance Organization	7.4%	Denver Health Medical Plan, Inc.
Cigna Health and Life Insurance Company	5.6%	Humana Health Plan, Inc.
USHealth Group	1.6%	Kaiser Foundation Health Plan of Colorado
HealthMarkets, Inc.	1.4%	New Health Ventures, Inc.
		Rocky Mountain Health Maintenance Organization

Connecticut

Pre-Reform (2011)		Issuers Applying to the Exchange (2014) [9]
Total Issuers: 4		**Total Issuers: 4**
Issuer	**Market Share**	**Issuer**
WellPoint	46.7%	Aetna
UnitedHealth Group	20.5%	Anthem
Aetna	17.1%	CTCare
EmblemHealth	8.0%	HealthyCT CO-OP

[5] List of issuers includes only those that were selected by the exchange. More than 13 issuers had applied.

[6] "Covered California Announces Plans and Rates for 2014" Covered California. May 23, 2013. http://coveredca.com/news/press-releases/pr-05-23-13-plans-anounced.html

[7] Aetna, Inc. and American Enterprise Mutual Holding Co. were listed in the pre-reform source data as non-group issuers of sufficient scale to meet our threshold test, but the Colorado Division of Insurance confirmed that these two issuers exited the non-group market in 2011, and therefore these issuers are not counted in our pre-reform tally. Personal communication from Vincent Plymell, Communications Manager, Colorado Department of Regulatory Agencies, June 14, 2013.

[8] "CEO's Update on Health Plan Prices and Competition" Connect for Health Colorado. June 7, 2013. http://www.connectforhealthco.com/news-events/news/ "Health Insurance Carriers - Plans Submitted for 2014" Colorado Division of Insurance. May 22, 2013.

[9] Personal communication from Julie Lyons of Access Health CT on May 31, 2013.

District of Columbia

Pre-Reform (2011)		Issuers Applying to the Exchange (2014) [10]
Total Issuers: 3		**Total Issuers: 3**
Issuer	**Market Share**	**Issuer**
CareFirst BlueCross Blue Shield	67.1%	Aetna
Aetna	11.9%	CareFirst BlueCross Blue Shield
Kaiser Permanente	8.0%	Kaiser Permanente

Maryland

Pre-Reform (2011)		Issuers Applying to the Exchange (2014) [11,12]
Total Issuers: 6		**Total Issuers: 6**
Issuer	**Market Share**	**Issuer**
CareFirst Blue Cross Blue Shield	68.1%	Aetna, Inc.
UnitedHealth Group, Inc.	17.2%	CareFirst Blue Cross Blue Shield
Aetna, Inc.	3.8%	Coventry Health Care
Kaiser Foundation Health Plan, Inc.	3.3%	Kaiser Foundation Health Plan, Inc.
Assurant, Inc.	3.1%	Evergreen of MD Cooperative
HealthMarkets, Inc.	1.7%	United Healthcare (All Savers Insurance Co.)

Massachusetts

Pre-Reform (2005)[13]		Issuers in the Exchange (2013) [14]
Total Issuers: 2		**Total Issuers: 9**
Issuer	**Market Share**	**Issuer**
Blue Cross Blue Shield of Massachusetts	80.0%	Neighborhood Health Plan
Harvard Pilgrim Health Care	15.0%	Harvard Pilgrim Health Care
		Blue Cross Blue Shield of Massachusetts
		Fallon Community Health Plan
		Tufts Health Plan
		Health New England
		Celticare
		Network Health
		BMC / HealthNet

[10] "Private Insurers Submit 293 Health Insurance Policies for Approval to Offer to Individuals, Small Businesses on DC Exchange" DC Health Benefit Exchange Authority. May 17, 2013. http://hbx.dc.gov/release/private-insurers-submit-293-health-insurance-policies-approval-offer-individuals-small. "Proposed January 2014 Rates for Health Insurance Products to be Sold in D.C. Health Benefit Exchange - Individual" DC.gov. (Accessed June 10, 2013). http://disb.dc.gov/sites/default/files/dc/sites/disb/publication/attachments/Proposed_Rate_Comparisons_for_HBX_Plans_0.pdf.

[11] Personal communication with staff of Maryland Insurance Administration on May 17, 2013.

[12] Maryland Health Benefit Exchange Announces Insurance Companies Authorized to Sell Qualified Health Plans Through Maryland Health Connection" Maryland Health Connection. May 28, 2013. http://marylandhbe.com/wp-content/uploads/2013/05/CarrierAnnouncementRelease.pdf.

[13] Carey, Robert and Gruber, Jonathan. "A Health Insurance Exchange For Maryland? – Comparing Massachusetts and Maryland", The Maryland Association of Health Underwriters and the National Association of Insurance and Financial Advisors of Maryland. 2010.

[14] Personal communication with Jean Yang of the Massachusetts Health Connector on June 4, 2013.

Oregon

Pre-Reform (2011)		Issuers Applying to the Exchange (2014) [15]
Total Issuers: 9		**Total Issuers: 12**
Issuer	**Market Share**	**Issuer**
Cambia Health Solutions, Inc.	34.5%	Atrio Health Plans, Inc.
Oregon Dental Service	16.5%	Bridgespan Health Company
PREMERA	13.3%	Familycare Health Plans, Inc.
Kaiser Foundation Health Plan of Northwest	9.1%	Freelancers CO-OP Oregon, Inc.
PacificSource Health Plans	8.1%	Health Net Health Plan of Oregon, Inc.
Providence Health Plan	7.6%	Kaiser Foundation Health Plan of Northwest
Assurant, Inc.	5.2%	Lifewise Health Plan of Oregon, Inc.
Health Net, Inc.	2.3%	Moda Health Plan, Inc.
HealthMarkets, Inc.	2.3%	Oregon's Health CO-OP
		Pacificsource Health Plans
		Providence Health Plan
		Trillium Community Health Plan, Inc.

Rhode Island

Pre-Reform (2011)		Issuers Applying to the Exchange (2014) [16]
Total Issuers: 1		**Total Issuers: 2**
Issuer	**Market Share**	**Issuer**
Blue Cross Blue Shield of Rhode Island	93.9%	Blue Cross Blue Shield of Rhode Island
		Neighborhood Health Plan of Rhode Island

Vermont

Pre-Reform (2011)		Issuers Applying to the Exchange (2014) [17]
Total Issuers: 2		**Total Issuers: 2**
Issuer	**Market Share**	**Issuer**
Blue Cross Blue Shield of Vermont	74.1%	Blue Cross Blue Shield of Vermont
MVP Health Care, Inc.	11.7%	MVP Health Care, Inc.

Washington

Pre-Reform (2011)		Issuers Applying to the Exchange (2014) [18]
Total Issuers: 6		**Total Issuers: 9**
Issuer	**Market Share**	**Issuer**
PREMERA	36.2%	Community Health Plan of Washington
Cambia Health Solutions, Inc.	32.6%	Coordinated Care Corp
Group Health Cooperative	21.3%	Group Health Cooperative
HealthMarkets, Inc.	4.4%	Molina Healthcare of Washington
Assurant, Inc.	1.7%	BridgeSpan Health Company
Kaiser Foundation Healthplan of the Northwest	1.3%	Premera BlueCross
		LifeWise of Washington
		Kaiser Foundation Healthplan of the Northwest
		MODA

[15] Personal communication from Katie Button of Cover Oregon on June 10, 2013. "Proposed Rates for 2014 Health Plans" Oregon Insurance Division. (Accessed on June 10, 2013) http://www.oregonhealthrates.org/?pg=proposed_rates.html.

[16] "2013 Health Insurance Premium Rate Review Process" Office of the Health Insurance Commissioner State of Rhode Island. (Accessed on May 17, 2013). http://www.ohic.ri.gov/2013%20Rate%20Factor%20Review.php.

[17] "Preliminary Rates Filings for Vermont Health Connect" Department of Financial Regulation. (Accessed on May 17, 2013). http://www.dfr.vermont.gov/insurance/preliminary-rate-filings-vermont-health-connect.

[18] "Washington Healthplanfinder Sees Competitive Health Plan Options for Consumers" Washington Healthplanfinder. (Accessed June 10, 2013). http://wahbexchange.org/press/press-releases/plans/.

CALIFORNIA HEALTHCARE FOUNDATION
SUPPORTING IDEAS & INNOVATIONS TO IMPROVE HEALTH CARE FOR ALL CALIFORNIANS

Ready or Not: Are County Safety-Net Systems Prepared for Reform?

Center for Studying Health System Change

Even with new federal resources to help, a study finds that counties with weaker safety-net systems are lagging in preparations for health reform.

June 2013

CHCF produces a series of market studies in six regions — Fresno, Los Angeles, Riverside/San Bernardino, Sacramento, San Diego, and the San Francisco Bay Area — to highlight variations in health care affordability, access, and quality of care across the state.

One issue that CHCF examined across all six regions is the status of county safety-net systems. Under the federal Patient Protection and Affordable Care Act (ACA), large numbers of Californians will become eligible for Medi-Cal in 2014. Even with federal resources to help safety-net providers prepare, however, communities with weaker safety-net systems are lagging in reform preparations.

As a result, low-income people in those communities may be left without health coverage and timely access to health care services. Even well-prepared communities will need time and assistance to help people gain health care coverage.

Key findings of this regional study of safety-net providers include:

- Almost all safety-net providers in the study reported concerns about sufficient funding and workforce to care for newly insured people and for those who remain uninsured.
- Safety-net providers are bracing for potential competition for insured patients from other providers and a consequent reduction in revenue.
- As federal and state policymakers launch Medi-Cal expansion and the health insurance exchange (Covered California), they may wish to coordinate with community safety-net leaders to focus resources and assistance to those communities that are further behind in preparing for national reform.

The complete issue brief is available under Document Downloads. The 2009 edition, as well as the six regional market studies, is available under Related CHCF Pages.

All of these issue briefs are published as part of the CHCF California Health Care Almanac, an online clearinghouse for key data and analysis examining California's medical system.

RELATED CHCF PAGES

Issues and Trends from a Six-Region Study of California Health Systems

Log in or sign up to share your thoughts.

Getting enrolled: The Community Service Society of New York's Nora Chaves helps a client enroll in health coverage. The society has applied to set up a statewide navigator network to help enroll people newly eligible for care under reform.

By Harris Meyer

DOI: 10.1377/hlthaff.2013.0438
HEALTH AFFAIRS 32,
NO. 6 (2013): 1023–1029

REPORT FROM THE FIELD

With Just Months To Go, New York State's Health Benefit Exchange Gears Up For Open Enrollment

Harris Meyer is the managing editor of *Modern Healthcare*, in Chicago, Illinois.

New York is a deep-blue state that Barack Obama won with 62 percent of the vote in both 2008 and 2012. Even so, the state's Republican-controlled Senate balked twice at approving a central feature of President Obama's signature health care reform law: a state health insurance exchange.

As a result, Democratic Gov. Andrew Cuomo had to issue an executive order in April 2012 to establish the New York Health Benefit Exchange. "Establishing the health exchange will bring true competition into the health care marketplace, driving down costs across the state," Cuomo said in a written statement when he issued the order.[1]

The Affordable Care Act requires an exchange in every state. New York, Rhode Island, and Kentucky are the only states that have established their new federally approved health insurance market by executive order. Thirteen others, plus the District of Columbia, have done so through legislation; Utah is awaiting federal approval of its legislatively created exchange. The remaining thirty-three states declined to set up an exchange on their own; as a result, in those states the federal government will run an exchange by itself or in partnership with the state.

Governor Cuomo's executive order came nearly a year after the New York legislature's failure to pass legislation. The delay has pushed the Empire State hard up against the deadlines for implementing the health insurance marketplace, which require starting enrollment on October 1, 2013, and coverage on January 1,

Photograph by Mary McGrail/CSS

2014. Yet, unlike many other states that are struggling to meet the quickly approaching deadlines, New York has the support of nearly all stakeholders, including Republican Senate leaders, as it works to establish a state-run exchange. Since the executive order was issued, the state has by most accounts moved efficiently to get enrollment started on time.

"New York is doing the best job one can expect given all the challenges," says New York Senate Health Committee chair Kemp Hannon (R–Nassau County), who in 2011 backed the bipartisan bill to create an exchange that didn't pass. "I haven't heard anyone griping," he adds. "But we're building something entirely new, and even Amazon had growing pains at the beginning."

The law's proponents say it's crucial for proreform states like New York, California, Maryland, and Oregon to have their exchanges up and running, enrolling people on October 1. Their success would demonstrate that the Affordable Care Act is working and would quiet critics like Sen. Max Baucus (D-MT), who recently warned of a "huge train wreck coming down" on exchange implementation.[2] President Obama acknowledged that launching the exchanges is "a big, complicated piece of business."[3]

Nationally, the state exchanges are expected to serve as a key mechanism in extending health coverage to an estimated twenty-seven million uninsured Americans by 2016 and in fostering competition that will curb health care cost growth. Nearly 1.6 million New Yorkers are projected to access coverage through the state's exchange.

"There are a lot of eyes on New York," says Donna Frescatore, a Cuomo health policy adviser and former state Medicaid director whom the governor appointed executive director of the exchange last July. "We're a large state, and we have the opportunity to significantly reduce the number of uninsured. There are a lot of very interested folks rightfully asking us good questions."

Skepticism Persists

Whether they know it or not, New York's 2.7 million uninsured residents—16 percent of the state's nonelderly population—have a lot riding on the exchange's success. One of them is Cynthia Morgan of Dunkirk, a town on Lake Erie south of Buffalo.

Morgan, a fifty-eight-year-old former hotel manager, has been out of work and uninsured for the past three years. The lack of insurance has been especially difficult because she has a heart condition, takes eight different prescription drugs, and—after a bad car accident—had to pay off $7,000 in medical bills out of pocket. She hasn't been to the doctor, even at a free clinic, in a year because she can't afford the preventive screening tests.

After learning that her family's income is too high for her to qualify for Medicaid, Morgan looked into buying private coverage but found it would cost her at least $300 a month—an unaffordable chunk of her husband's $1,700 monthly Social Security check. She's a prime candidate for the New York exchange.

Morgan admits that she doesn't know much about the Affordable Care Act or the exchange. And when she is told that people like her with a household income of less than 400 percent of the federal poverty level will qualify for either expanded Medicaid or federal subsidies to help them buy coverage, she is skeptical.

National polls show that most Americans in her position also lack knowledge about the health care law's benefits. A recent Enroll America survey found that 78 percent of uninsured people did not know they will have access to "a quality health insurance plan" that they can afford.[4] In addition, 42 percent of Americans were unaware that the Affordable Care Act was still in effect, according to a recent Kaiser Family Foundation survey.[5]

Morgan can envision what it would mean for her if the law's promise is fulfilled. "Oh, God, that would be great—if there's going to be a plan that's affordable," she says. "But come on now, it's really hard to believe."

The fate of the New York exchange will depend heavily on the state's effectiveness in getting the word out and enrolling uninsured people like Morgan. It also will hinge on signing up small businesses—those with fewer than fifty-one full-time employees—to buy coverage for their employees in the state's separate Small Business Health Options Program, known as the SHOP exchange. Many small businesses currently don't insure their workers, saying they can't afford to do so.

Enrollment in New York's individual exchange is projected to reach 615,000 and another 450,000 in the SHOP exchange.[6] Nearly 60 percent of those expected to sign up in the individual exchange were previously uninsured.[7] It's estimated that another 510,000 uninsured people will be eligible through the exchange for Medicaid or the state's Child Health Plus public coverage, including 75,000 who will be newly eligible under the expanded Medicaid program and 435,000 who are currently eligible but not enrolled.

But many observers are nervous. As of early May, the New York Department of Health had not announced a plan for public education, outreach, and enrollment. It has received applica-

tions from organizations seeking to provide "navigator" services to help individuals and small businesses interested in buying coverage through the exchange. The department is not expected even to announce what navigators it has chosen to work with until July.

"We're concerned about the timing," says Elisabeth Benjamin, vice president of health initiatives for the Community Service Society of New York, which runs a consumer assistance program that helps people with questions about health insurance. The organization has applied to set up a statewide navigator network. "To get people trained as navigators by the time of open enrollment seems unlikely."

Early Stumbles

Despite ongoing concerns, stakeholder groups are relieved that New York's state-run exchange was established in the first place. That almost didn't happen because of a combination of timing, a busy legislative agenda, and conservative opposition to President Obama's health reform law.

In June 2011 Governor Cuomo reached an agreement with the leaders of both houses of the state legislature—the Assembly is controlled by Democrats, the Senate by Republicans—on a bill to establish a state exchange run by an independent public authority, governed by a board of representative stakeholders. Initially, Cuomo had envisioned an exchange that would engage in aggressive selective contracting with health plans, while Senate Republicans and the health insurance industry preferred an open-market model that would allow any plan meeting exchange criteria to participate. The legislation that moved forward was a compromise.

The Assembly passed the bill, which then went to the Senate—where it was expected to pass. The Senate Republican Conference took the bill up on June 23, 2011, the next-to-last night of the legislative session, which had been consumed with controversial bills on same-sex marriage and capping property tax growth. Senate Health Committee chair Hannon says GOP leaders simply decided they didn't have time to consider the complicated exchange bill. Its failure stunned everyone.

Governor Cuomo reintroduced the bill early in the 2012 legislative session as part of his proposed budget. But by then the presidential election campaign was in full roar, and fiery opposition to "Obamacare" had become a litmus test within the national Republican Party. The longtime Assembly Health Committee chair, Richard Gottfried (D–New York City), says state Senate Republican leaders refused to take up the exchange bill, arguing that the issue would be moot if the US Supreme Court struck down the Affordable Care Act or Obama was not reelected.

Soon after, Governor Cuomo announced that he had analyzed state law and concluded it allowed him to order the Department of Health to set up the exchange as a bureau within the department, although he couldn't unilaterally establish an independent public authority to run the exchange. He issued his executive order April 12, 2012.

"We were lucky here that we have a strong governor who said it was ridiculous to wait until it would be too late to set up our own exchange," says the Community Service Society's Benjamin. "From a consumer perspective, that was the right call."

After the governor issued the order, Gottfried says, "there was not a peep of controversy. That's because while Senate Republicans may not have wanted their fingerprints on it, all the stakeholders, including the insurers, very much wanted an exchange and they didn't want Washington running New York's insurance market."

The extended legislative impasse delayed exchange implementation to some degree. In the interim, however, the New York State Health Foundation supported a number of studies, including reports about consumer protections, customer assistance, key business functions of the exchange, and the role of brokers. The results of these studies helped the state get off to a fast start once it finally established an exchange.

Since Governor Cuomo's executive order, New York has received nearly $370 million in federal implementation grants. Under the Affordable Care Act, every state exchange must be financially self-sufficient by 2015. New York has not yet announced how it plans to finance the exchange's day-to-day operations after 2014, although it's expected to impose user fees, as most states probably will. The budgeted 2014 operating cost of $120 million will be fully funded by the federal government; over the two years that follow, the budget drops to $97 million, then $75 million.

In most states with an exchange, the legislature created an independent public authority to oversee the development and operation of the new marketplace. The long-term impact of New York's less common approach remains to be seen.

The Cuomo-ordered exchange is housed within New York's Department of Health, an executive branch agency that oversees Medicaid, other public insurance programs, and some health maintenance organizations. But it is the state's Department of Financial Services that oversees other types of commercial health plans.

"It's one of those ironic things that it's probably working out better than the original concept," Hannon says. "You have people sticking with their areas of competency, and you avoid duplicate functions."

But others, including some who generally praise the Department of Health's work on the exchange, say that having the exchange within the executive branch rather than under an independent public authority has led to less transparency and public engagement. Austin Bordelon, an analyst with Leavitt Partners, which tracks exchange efforts nationally, says that compared with Oregon—a pacesetter in transparency—New York has provided little visibility into its exchange development process.

The Community Service Society's Benjamin agrees in part. "Press outreach and external affairs are very tightly controlled," she says. "It's not that we don't trust them, but people are feeling nervous that we haven't had a public stakeholder meeting since last November. The state feels a little bunkered in."

Building On A Strong Foundation

Compared with other states' exchanges, New York's exchange started off with some major advantages—as well as some distinct disadvantages.

The most obvious advantage is that the state has a strong tradition of regulating health care markets that's widely accepted by stakeholder groups and both Republicans and Democrats. As a result, when the New York exchange announces plan premiums later this summer, consumers are unlikely to experience the so-called rate shock that purchasers in most other states may experience.

Across the country, health plans have warned that they'll have to jack up premiums because of the Affordable Care Act's requirements: Starting January 1, 2014, all health plans must accept applicants without regard to preexisting medical conditions and must limit the differences in the premiums they charge that are based on age, sex, and medical condition, so that no one group pays more than three times what another group pays. Younger, healthier people will pay more, and older, sicker people will pay somewhat less.

The difference in New York is that the state already requires insurers to accept all applicants in the individual and small-group markets. Regulators also have established a system in which insurers have to charge everyone in the same market the same premium, regardless of age or health status.

When implemented in the 1990s, these rules led to a sharp increase in premiums, particularly in the individual market, and a dramatic reduction in the number of New Yorkers purchasing coverage in the individual market. Only about 17,000 people now have such insurance, and they each pay as much as $1,300 a month. Today, the same rules are expected to ease New York's transition into next year's reformed insurance market.

A recent Society of Actuaries report projected that premiums in New York's individual market would decrease 13.9 percent in 2014. That would be the largest drop in the country. In states with little or no previous insurance market reforms, rates are projected to increase as much as 81 percent.[8]

"The bad news is we've been paying high rates all along," says David Sandman, senior vice president of the New York State Health Foundation. "The good news is they won't get worse and will probably get better."

Another advantage is that unlike some states that are dominated by a small number of insurers and provider systems, New York has relatively robust competition in both the insurance and hospital markets in many of its regions. There are nearly forty insurers doing business in the state, including about a dozen with significant market share.

As a result, most observers predict that New York's exchange will offer an adequate number of health plans in each regional market—a major worry for exchanges in other states. Participating plans may include national insurers like Oxford and Aetna; nonprofit health maintenance organizations (HMOs) such as the Capital District Physicians' Health Plan; Blue Cross Blue Shield plans, including Empire and Excellus; the state's nonprofit CO-OP (Consumer Oriented and Operated Plan), the Freelancers Insurance Company; and plans sponsored by hospital systems. The exchange also may include Medicaid managed care plans, such as Fidelis, that obtain commercial licenses to serve exchange customers.

"I think there probably will be six or seven plans participating in the small-group exchange in most of the twenty-four counties we cover," predicts Robert Hinckley, chief strategy officer for the Capital District Physicians' Health Plan, whose Albany-based HMO serves 400,000 commercial, Medicare, and Medicaid members. "We're planning on being active in the individual exchange as well. I'm optimistic there will be participation. I think most of the plans are looking at this as a defensive play to keep the groups they have."

In addition to the New York exchange's built-in advantages, some clear challenges remain. With a highly diverse population of nearly twenty

million people and multiple complex and fragmented regional markets, New York will not be the easiest state in which to conduct outreach and enrollment.

It's estimated that 37 percent of the potential enrollees in New York's individual exchange speak a primary language other than English—and 19 percent have a primary language that is neither English nor Spanish.[6] That's why stakeholders are eager to hear exchange officials' plans for public outreach and enrollment, and why they put so much importance on the navigator program, which will provide help to consumers in their own languages.

Exchange officials know that effective outreach is crucial. They encouraged a wide range of organizations, including chambers of commerce and trade organizations, to apply to serve as navigators, and they decided to allow insurance brokers to sell exchange products to both individuals and small businesses. The state plans to spend nearly $30 million a year on navigator assistance for consumers. Plans for the public outreach campaign were scheduled to be discussed at regional public advisory committee meetings in late May.

"We need an 'all hands on deck' approach," says Frescatore, the exchange's executive director. "Our outreach efforts will focus on those populations that are the most difficult to reach. We know our ability to reduce the number of uninsured is highly dependent on our outreach strategies and partnerships."

Tough Decisions Ahead

Even with those reassurances, stakeholder groups are fretting because there is so little time before October 1 to work through the enormous challenges and myriad policy decisions involved in setting up a working exchange.

Health plans had to scramble to file applications to offer products on the exchange, including listing their proposed rates, by the end of April 2013; the invitation to plans only went out February 1. Meanwhile, plans continue to negotiate with hospitals and other providers to line up their networks. The Department of Health says it won't announce what plans will be offered on the exchange, their premiums, and their networks until later this summer.

Health plans are concerned about whether enough young and healthy people will sign up for exchange coverage to lower the overall premiums. They also are wary about whether the Department of Financial Services, which has premium approval authority, will approve rates that will be adequate to cover the costs of the exchange risk pool. Given how small the individual market has been until now, New York insurers have less experience than those in other states when it comes to setting rates for individual purchasers.

"Our concern is plans will come in at one rate level, the Department of Financial Services will come back with a rate that's substantially less, and then there's the question of whether plans will participate in the exchange or not," says Paul Macielak, president of the New York Health Plan Association. "We're concerned about allowing enough time for a dialogue."

Hospital systems and physicians face tough decisions about whether to join health plans' networks. Those plans are negotiating aggressively on reimbursement rates. Yet, because no one knows how sick the exchange population will be, hospitals are struggling to predict the costs of serving this group. Frescatore says that she has reassured hospitals that exchange health plans would not base their reimbursement rates on low Medicaid inpatient rates.

"Hospitals are anxious to support the idea of exchanges to increase affordable and accessible care," says Jeffrey Gold, vice president for insurance at the Healthcare Association of New York State. "But the rate structures may or may not be good deals for hospitals. So they're having to make tough choices in a compressed time frame, without a lot of information."

Hospitals also fear that many consumers will choose plans with lower premiums and higher cost sharing, forcing providers to spend more time collecting copayments and coinsurance from patients—a task they loathe. "If there's a migration to bronze and silver plans with higher copays, as there was in Massachusetts, we will have increased headaches," Gold says. "Chasing individual patient responsibility is one of the hardest things for hospitals to do, and we'd love not to do it."

Small-business owners express uncertainty about whether premiums for plans offered through the exchange will be affordable. Additional costs from mandated essential health benefits, a health insurance tax required by the Affordable Care Act, and the surcharge that the exchange is likely to impose to cover its own administrative costs all could drive up premiums.

The equation is somewhat different for businesses with twenty-five or fewer employees and average wages of less than $50,000. Those businesses will be eligible for a sliding-scale tax credit if they buy coverage through the SHOP exchange and pay at least half of the premiums for their workers. Yet many small business owners remain skeptical that the exchange will be a financially attractive proposition.

They also wonder whether their employees will have a choice of plans through the SHOP exchange, or whether it will be the business owner's responsibility to pick a single plan for all employees. According to a survey conducted by New York exchange officials, Frescatore reports, 76 percent of small-business owners said that they would like their employees to have a choice of plans in the SHOP exchange. The Obama administration had intended to require state SHOP exchanges to offer small-group employees that choice, but it has delayed implementing the rule because it's technically difficult for the exchange to let each employee enroll in a separate plan. New York's SHOP exchange nevertheless intends to go ahead and offer each worker at participating small businesses a choice of plans.

Under that model, employers will contribute a fixed amount every month to cover their employees through the SHOP exchange. Each employee will apply those funds to a plan that he or she chooses, paying the difference if the premium is higher than the employer's contribution.

Complicating matters is the fact that the SHOP exchange will not be the only place where small businesses can buy group coverage. A growing number of employee benefit firms are launching private exchanges—such as HealthPass in New York—which offer employers administrative support and a choice of health plans for their workers.[9] In addition, most small employers in New York buy health insurance through brokers, and the broker community remains skeptical about the SHOP exchange.

"What you may see is plans outside the exchange that are more creative in their benefit packages that may fit better with particular consumers," says Dick Poppa, CEO of the Independent Insurance Agents and Brokers of New York, a trade association. "There certainly is conversation about, 'What if we have an exchange and no one comes?'"

Meanwhile, consumers are waiting to see whether federal subsidies will make premiums and cost sharing in the individual exchange affordable enough for the most vulnerable consumers. Much depends on how many people sign up, and who they are. If enrollment is both heavy and balanced between healthier and sicker people, premiums may stop climbing or even drop. But if mostly sicker people sign up, rates could rise even higher.

Everyone is wary of predicting how successful enrollment will be at the start, especially given the relatively small federal tax penalty that individuals will have to pay if they do not obtain insurance. "Whatever the rate is, for someone who doesn't have insurance today, it's going to be more than they want to spend and more than the penalties, and that will dampen the take-up," says the health plan association's Macielak.

The Final Push

For their part, Frescatore and her fellow exchange officials face numerous challenges, including the urgent need to get a smoothly functioning web portal up and running to enroll people by October 1. New York has hired Virginia-based Computer Sciences Corporation, which also runs its Medicaid billing system, to design the exchange web portal.

Exchange officials envision one-stop shopping online, where individuals and families can sign up for subsidized or unsubsidized private plan coverage, Medicaid coverage, or the state's Child Health Plus coverage. Their goal is to have the system automatically funnel applicants into the program for which they qualify and then present them with that program's coverage options. The exchange also will offer telephone assistance, and navigators and brokers will be available to give consumers help in person.

Exchange officials also are counting on the federal government's data hub to be operational by the time enrollment begins. The hub, now in testing, aims to provide a real-time link to information from the Internal Revenue Service, Department of Homeland Security, and other federal agencies. That connection will enable the exchanges in New York and other states to instantly determine applicants' eligibility to participate and receive federal subsidies to buy coverage.

On top of all this, exchange officials still have a major decision to make: Will they choose which plans will be offered? Or will any plan that qualifies be allowed to participate? Governor Cuomo prefers the former—a selective approach that Massachusetts took as part of its earlier reform efforts and that California officials intend to implement as well. Although New York exchange officials haven't announced any explicit policy on this, they have signaled that they want to take a middle road between aggressively limiting plan participation and letting everyone play. But first they want to see what products insurers have proposed in response to the plan invitation.

The New York State Health Foundation's Sandman suspects that exchange officials at first will not be very aggressive about selective contracting. "The thinking is, let's create an attractive marketplace that health plans want to participate in," he says. "If we have a working model, we can raise standards and use more purchasing power later. But let's not sink this ship before it even starts to sail."

Under the Affordable Care Act, insurance

products offered through the exchanges must fit within bronze, silver, gold, and platinum tiers that range from covering 60 percent to 90 percent of a policyholder's total health care costs. The act also allows a catastrophic, high-deductible tier for people younger than thirty. All products offered both inside and outside the exchange must cover at least an essential benefit package that is actuarially equivalent to the state's chosen benchmark plan—which in New York is Oxford's exclusive provider organization, a popular plan currently available to small groups in the state.

Some experts fear that within each tier, insurers will offer many different and potentially confusing plan variations. "We heard that too much choice is overwhelming and consumers need to have manageable choice," Frescatore says. "But we also wanted to preserve plan innovation. We wanted to come up with an approach so consumers could have an apples-to-apples comparison of exchange offerings in terms of premium, cost, provider network, and quality ratings."

The insurance industry seems comfortable with New York's approach so far. "Unlike other states, New York hasn't said anything about moving to selective contracting," says Macielak. "You can go to regions of the state where there are maybe three plans, and we don't know if all three intend to participate in the exchange. I don't know how selective you want to be."

Looking at the multitude of challenges and the tight time frame for implementing the exchange in New York and other states, politicians and pundits already are predicting a difficult road. Even President Obama recently said, "Even if we do everything perfectly, there'll still be…glitches and bumps."[3]

Across the country, Republican elected officials have blocked state-run exchanges in most states, adding to federal officials' burden and increasing the chances of problems. Congressional Republicans have also refused to approve President Obama's budget request for $1.5 billion next year to help implement the exchanges and conduct a broad public education campaign about enrollment.

Political observers say that Republicans hope to exploit exchange snafus to argue that "Obamacare" is a failure and to make gains in the 2014 congressional elections,[10] with an eye to rolling back or repealing the landmark health care law.

"If it crashes and burns on October 1," Sen. Johnny Isakson (R-GA) recently warned the federal official in charge of exchange implementation, "you've got a huge problem."

The stakes for leading reform states like New York are high, and New York officials are acutely aware of that. "If we can't do it well here, that will undermine people's confidence overall," says Assembly Health Committee chair Gottfried. "It's important that we not screw it up." ■

NOTES

1 Governor's Press Office [Internet]. Albany (NY): Governor's Press Office. Press release, Governor Cuomo issues executive order establishing statewide health exchange, 2012 Apr 12 [cited 2013 May 13]. Available from: http://www.governor.ny.gov/press/04122012-EO-42

2 Morgan D. Senator gives administration "F" on public education for health-care law. Washington Post. 2013 Apr 17.

3 Kaiser Health News. Transcript of President Obama's remarks on April 30, 2013 [Internet]. Menlo Park (CA): Kaiser Family Foundation; 2013 Apr 30 [cited 2013 May 17]. Available from: http://www.kaiserhealthnews.org/Stories/2013/April/30/obama-health-care-transcript-news-conference.aspx

4 Enroll America. Informing Enroll America's campaign: findings from a national study [Internet]. Washington (DC):Enroll America; 2013 Feb [cited 2013 May 13]. Available from: http://files.www.enrollamerica.org/best-practices-institute/public-education-resources/Enroll_America_Survey_Final_Report.pdf

5 Kaiser Family Foundation. Kaiser health tracking poll: April 2013 [Internet]. Menlo Park (CA): KFF; 2013 Apr 30 [cited 2013 May 13]. Available from: http://kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-april-2013/

6 Rothstein S. New York Health Benefit Exchange: health care for all New York [Internet]. Albany (NY): The Exchange; 2013 Mar 28 [cited 2013 May 13]. Available from: http://hcfany.files.wordpress.com/2013/04/sara-rothstein_nyhbe_032813.pdf

7 New York Health Benefit Exchange. Characteristics of New York's Health Benefit Exchange enrollees: individual and SHOP exchange [Internet]. Albany (NY): The Exchange; [cited 2013 May 14]. Available from: http://www.healthbenefitexchange.ny.gov/sites/default/files/Exchange%20Enrollees%20-%20Demographic%20Characteristics-%20Graphics.pdf

8 Society of Actuaries. Cost of the future newly insured under the Affordable Care Act (ACA) [Internet]. Schaumburg (IL): SOA; 2013 Mar [cited 2013 May 13]. Available from: http://cdn-files.soa.org/web/research-cost-aca-report.pdf

9 Banham R. The pros and cons of private health insurance exchanges. Business Insurance [serial on the Internet]. 2013 May 13 [cited 2013 May 13]. Available from: http://www.businessinsurance.com/article/99999999/NEWS030103/120429897?tags=%7C332%7C62%7C278%7C342

10 Calmes J. New worries for Democrats on health law. New York Times. 2013 May 6.

accenture

consulting | technology | outsourcing

Are You Ready? Private Health Insurance Exchanges Are Looming

Accenture Research shows: By 2017, nearly 1 in 5 Americans will purchase benefits from a health insurance exchange, yet consumers are unaware and ill prepared

Considerable attention has been paid to the state health insurance (public) exchanges created by the Patient Protection and Affordable Care Act. These public exchanges will expand and standardize coverage for an estimated 30 million individuals by 2017[1]. However, this transformation is also paving the way for the rapid growth of another quietly emerging channel. Private health insurance exchanges have been incubating for several years, but the accelerated development of exchange products and technologies has employers increasingly re-evaluating traditional employee benefits.

Private health insurance exchanges will rapidly upend insurance purchasing for many of the 170 million people who receive benefits through their employer. According to Accenture research, private exchange participation will approach public exchange enrollment levels as soon as 2017 and surpass them soon thereafter. The result:

In 2017 approximately 18 percent of the American public will purchase insurance through exchanges, radically transforming the health insurance landscape.

Private exchanges facilitate employers' move to a defined contribution funding strategy to better manage future cost trends and offer employees greater choice, flexibility and a retail-like shopping experience. While the market has remained fairly nascent with fewer than one million enrollees in 2012, employers are expressing tremendous interest. Recent employer surveys indicate that more than 1 in 4 employers are considering moving to a private exchange in the next three to five years[2,3]. Correspondingly, several benefits consultancies—Aon Hewitt, Buck Consultants, Mercer, Towers Watson—and a number of health plans are launching private exchanges to meet this expected demand.

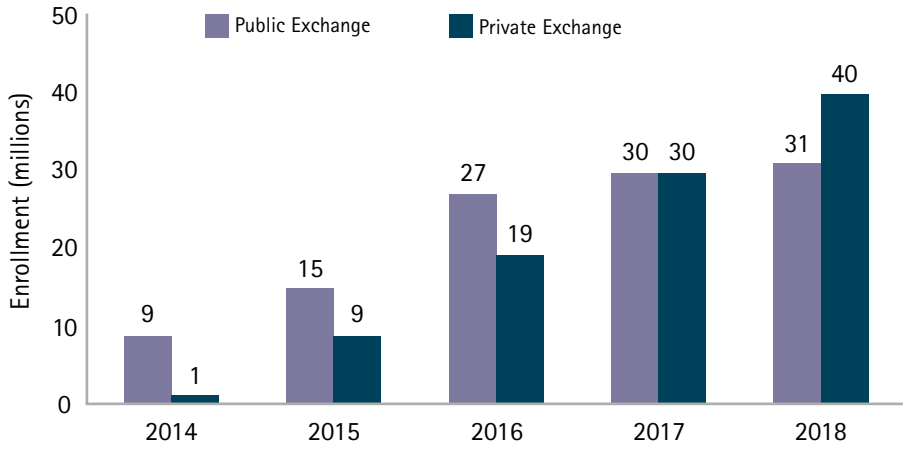
A private (health insurance) exchange is an online benefits marketplace that lets individuals shop for insurance products including health, dental, vision, life, auto and home. Typically an employer will provide a "defined contribution" (e.g., $5,000 that works like a gift card) that can be used to purchase products that best meet individuals' needs, offering greater choice and flexibility than traditionally available.

[1] Congressional Budget Office: Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage, February 2013.

[2] NY Times (2/28/13): According to Aon Hewitt's survey, about 28 percent plan to move into a private health care exchange over the next three-to-five years.

[3] Wall Street Journal (4/15/13): "With 56% of employers considering a private exchange to provide benefits to their active employees or retirees, the transformation of the US health care landscape is well underway," said David Rahill, President, Health & Benefits, Mercer.

Public vs. Private Exchange Annual Enrollment



Source: Private Exchange: Accenture analysis, based on data from: U.S. Census, Bureau of Labor and Statistics, Kaiser Employer Health Benefits 2012 Annual Survey. Calculations exclude post-65 retirees and individuals.

Public Exchange: Congressional Budget Office 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage, CBO's February 2013 Baseline, depicts average monthly enrollment, including spouses and dependents for individual and SHOP.

Let the buyer beware

While private exchanges may be top of mind for employers, employees are largely unaware of this emerging model. According to a recent Accenture survey of 2,000 US consumers, 83 percent of consumers are entirely unfamiliar with the private exchange concept. A similar lack of awareness exists about public exchanges[4]. This lack of awareness is pervasive across all demographic categories.

Widespread employer interest paired with markedly low consumer awareness suggests there may be material, latent demand for the private exchange model. Accenture research revealed that once presented with the concept, 85 percent of those surveyed expressed a neutral to positive outlook.

Respondents are attracted to choice, flexibility, the personalized product selection and the shopping experience. In fact, the majority of respondents are even willing to share personal information about themselves and their families to receive personalized recommendations through the platform. This latent employee demand will further accelerate private exchange adoption.

Private exchange providers have been largely focused on educating employers of the concept's benefits. However, private exchanges will shift considerable financial responsibility to employees, expanding choice yet requiring users to become superior individual risk managers. This creates tremendous opportunity for carriers, brokers and employers to take credit for an enhanced experience, yet also creates equally tremendous risk as dissatisfied consumers will blame plan sponsors. The majority of survey respondents remain wary that firms are merely looking to shift costs to employees—a notion that employers should quickly work to dispel.

Rapidly expanding private exchanges will increasingly enter c-suite conversations. Adoption has accelerated substantially, and will continue to do so as public and private exchanges demonstrate legitimacy and early vendors mature their offerings. However, this velocity of change will surprise a largely unaware consumer population. This may result in negative consequences for those who lack the education, support, and tools required to effectively manage increased responsibility for personal health care risk. Effectively addressing this latent demand and supporting consumer success are critical success factors for aspiring market leaders.

For more information, contact:

Richard Birhanzel
richard.f.birhanzel@accenture.com

Scott Brown
j.scott.brown@accenture.com

Joshua Tauber
joshua.tauber@accenture.com

[4] Kaiser Health Tracking Poll: March 2013 finds a majority of Americans are unsure of how the ACA will affect them. While 58% of respondents in this poll said they understood that exchanges are a provision of the law, this level of awareness declined from 62% in an April 2010 poll. http://kff.org/health-reform/poll-finding/march-2013-tracking-poll/

Methodology

Accenture conducted an online survey of 2,000 consumers in the United States. The survey assessed consumers between the ages of 18 and 64 who receive health insurance through their employer or other affiliation, their significant other, or individually. The research was conducted in March 2013.

Accenture: Insight Driven Health

Insight driven health is the foundation of more effective, efficient and affordable healthcare. That's why the world's leading healthcare providers and health plans choose Accenture for a wide range of insight driven health services that help them use knowledge in new ways—from the back office to the doctor's office. Our committed professionals combine real-world experience, business and clinical insights and innovative technologies to deliver the power of insight driven health. For more information, visit: www.accenture.com/insightdrivenhealth.

About Accenture

Accenture is a global management consulting, technology services and outsourcing company, with approximately 261,000 people serving clients in more than 120 countries. Combining unparalleled experience, comprehensive capabilities across all industries and business functions, and extensive research on the world's most successful companies, Accenture collaborates with clients to help them become high-performance businesses and governments. The company generated net revenues of US$27.9 billion for the fiscal year ended Aug. 31, 2012. Its home page is www.accenture.com.

NEW REPORT RELEASE—May 1, 2013

For more information, contact:
Nadia Siddiqui
Texas Health Institute
nsiddiqui@texashealthinstitute.org

New Report Offers Status and Guidance on Addressing Race, Culture, and Language in Health Insurance Marketplaces

Of the projected 24 million individuals who will obtain individual coverage through Health Insurance Exchanges or Marketplaces by 2019, 42 percent (or 10 million) will be from racially and ethnically diverse communities. While the Affordable Care Act includes explicit requirements for non-discrimination, language access, and cultural appropriateness in the Exchanges, narrow deadlines and tight budgets coupled with limited federal guidance have made this task demanding for states and organizations.

The Texas Health Institute released a new report, "Implementing Cultural and Linguistic Requirements in Health Insurance Exchanges," supported by Kaiser Permanente's Community Benefit National Program Office, in collaboration with the W.K. Kellogg Foundation and The California Endowment. This first-of-its-kind report offers a point-in-time update on progress and timely guidance, best practices, and tools for states and organizations hastening to implement the ACA's cultural and linguistic requirements by October 1, 2013, when open enrollment begins. Featured in the report are seven in-depth case studies on state-based exchanges in California, Colorado, Connecticut, Maryland, New York, Oregon, and Washington, with information on best practices on integrating race, culture, and language in planning and operations.

"This report has revealed how some of the leading states have clearly made health equity a central priority in creating their Marketplaces and are working to assure that this goal is integrated into their actions," commented Dennis Andrulis, the project's Director. He added that "the report, in telling the stories emerging from these states and their communities, has identified promising practices in designing exchanges and their early efforts to engage communities and health care providers in reaching, enrolling, and assuring diverse residents understand how to become insured."

The audience for this report is broad, and includes states that can benefit from lessons learned and best practices on engaging racially and ethnically diverse communities and designing strategies to address culture and language in outreach and enrollment. Health plans and providers can learn about new requirements and what peers are doing to prepare for exchange participation. And community-based and advocacy organizations can draw on opportunities to collaborate and be engaged to assure equity is integral to their state's exchange.

This report is a part of a major initiative known as the *Affordable Care Act & Racial and Ethnic Health Equity Series* to track, analyze, and report on the implementation progress and evolution

of over 60 provisions in the ACA aimed at eliminating racial and ethnic health disparities and advancing equity across five priorities: (1) health insurance exchanges; (2) health care safety net, (3) workforce support and diversity; (4) data, research, and quality; and (5) public health and prevention. This *Series* represents the first comprehensive undertaking to report on implementation progress and provides a unique compilation of resources for taking the equity objectives of the ACA from vision to reality.

Following this release, an additional four reports on the remaining topics will be rolled out in the coming months, all featuring user-friendly updates on the law, highlighting tangible funding and program opportunities, sharing experiences and challenges, and offering practical information on important tools, resources, and guidance that can inform states and other organizations as they work to implement the ACA to advance racial and ethnic health equity. Finally, this work is intended to contribute to a stronger advocacy to ensure that race, culture, and language remain a core and integral part of transforming the U.S. health care system.

To access these reports and related resources on health care reform and equity, including an enhanced executive summary of the exchange report, please visit http://www.texashealthinstitute.org/health-care-reform.html.

Lucile Packard Foundation for Children's Health

Issue Brief

May 2013

Habilitative Services Coverage for Children Under the Essential Health Benefit Provisions of the Affordable Care Act

by Sara Rosenbaum, George Washington University School of Public Health and Health Services

Executive Summary

Habilitative services are defined by the National Association of Insurance Commissioners as "health care services that help a person keep, learn or improve skills and functioning for daily living." Whether health insurance covers habilitative services is a matter of great importance in child health policy, because of the prevalence of developmental disabilities among children. In 2008, nearly one in seven U.S. children experienced a physical or mental health condition that led to some level of developmental disability, a figure 17% higher than a decade earlier.

The Affordable Care Act's essential health benefit (EHB) provisions establish coverage standards for the individual and small group health insurance markets, and habilitative services and devices are included in the EHB definition. The implementation approach taken by the Obama Administration makes state law the primary source of regulatory policy in defining EHBs. In the absence of state standards, the Administration has elected to give broad deference to the health insurance industry to define the level of habilitative services coverage. Under federal regulations issued in February 2013, insurers will be permitted not only to define the benefit but also to engage in "substitution" of greater rehabilitative services for adults in favor of lesser habilitative services for children.

Whether health insurance covers habilitative services is a matter of great importance in child health policy.

Establishing state standards for health insurance plans sold in the individual and small group markets (including Qualified Health Plans [QHP] sold in the Health Insurance Marketplace) thus becomes key to health policy for children with disabilities. The evidence suggests that to date, only some states have addressed this issue. Key regulatory issues encompass coverage definition, permissible limitations and exclusions, medical necessity evaluation, the permissibility of substitution, and the interaction between habilitative services and mental health parity.

Introduction

This analysis examines coverage of habilitative services for children under the essential health benefits (EHB) provisions of the Affordable Care Act (ACA). The issue of habilitative services coverage is of major importance in child health policy because of the prevalence of

developmental disabilities among children. In 2008, nearly one in seven U.S. children experienced a physical or mental health condition that led to some level of developmental disability. [1] This figure represents a 17 percent increase over the proportion of children experiencing such disabilities a decade earlier. Considerable evidence shows that intervention at the earliest time with a range of therapies aimed at developing physical, mental, cognitive, and socialization skills can be effective in reducing the severity and scope of developmental delays.[2]

Because of the complex manner in which the EHB provisions of the law interact with various sources of health insurance, the analysis focuses on several distinct health insurance markets: (1) Medicaid and separately administered CHIP programs; (2) the individual and small group (under 100 employees) health insurance markets; and (3) the large group market, whether fully insured or self-insured. In addition, the analysis touches on the relationship of the EHB provisions to health plans that maintain "grandfathered" status.

This analysis finds that the essential health benefits provisions of the ACA have significantly advanced access to habilitative services coverage for children in the individual and small group markets. However, it also finds that final federal EHB regulations, issued by the United States Department of Health and Human Services in February 2013, may actively incentivize EHB-governed health plans to reduce habilitative services for children in favor of more comprehensive rehabilitative services for adults. Because of the primary role played by states in defining the scope of EHB coverage, state health policy becomes extremely important to the strength of habilitative services coverage for children.

This analysis begins with a background that reviews the habilitative services coverage landscape prior to passage of the ACA. It then describes the EHB amendments and the course of federal agency implementation. The analysis concludes with a discussion of issues that arise as the amendments are translated into coverage in state markets.

Background: Pre-ACA Coverage of Habilitative Services for Children

Private insurance, employer-sponsored plans

The National Association of Insurance Commissioners (NAIC), whose model laws and policies are considered authoritative in the field of insurance regulation, defines the term "habilitative services" as "health care services that help a person keep, learn or improve skills and functioning for daily living."[3] Prior to enactment of the ACA, coverage of habilitative services, whether for children or adults, was effectively confined to the Medicaid program. To be sure, strong advocacy in recent years led to measurable gains in standards governing habilitative services coverage under private insurance in the case of children with autism spectrum disorders. Indeed, as of August 2012,

[1] C. Boyle et al., "Trends in the Prevalence of Developmental Disabilities Among U.S. Children, 1997-2008," *Pediatrics* (published online, May 23, 2011) [accessed online at Centers for Disease Control and Prevention, *Developmental Disabilities Increasing in the U.S.* http://www.cdc.gov/features/dsdev_disabilities/index.html (May 10, 2013)]

[2] Id.

[3] National Association of Insurance Commissioners, Glossary of Health Insurance Terms http://www.naic.org/documents/committees_b_consumer_information_ppaca_glossary.pdf (Accessed online May 4, 2013)

37 states reported at least some insurance coverage of applied behavioral therapy for children with a covered diagnosis related to autism spectrum disorders.[4] Inevitably, as with state insurance benefit mandate laws generally, state laws governing habilitative services coverage may vary considerably in terms of the level of diagnosis necessary to trigger coverage, the amount, duration and scope of coverage available, permissible types of treatment limitations and exclusions, and permissible cost-sharing. Moreover, as state laws related to autism treatment coverage underscore, state coverage law advances may be limited to certain specific diagnoses.

In its 2011 report on the ACA's EHB provisions,[5] the Institute of Medicine (IOM) noted that habilitative services are distinct from rehabilitative care, since they are designed to help a person attain a particular function as opposed to restoring a prior level of functioning. Recognizing the extremely limited nature of commercial insurers' experience with habilitative services coverage, the IOM also pointed out that insurers and health plans have extensive experience with coverage of rehabilitative services, which consist of similar physical, cognitive, and mental health therapies, although carried out for a different purpose.

Insurers and health plans have used an array of techniques to exclude coverage of treatments and therapies when needed for habilitative reasons.

Despite the similarities between rehabilitative and habilitative treatments, as the IOM noted, insurers and health plans traditionally have used an array of techniques to exclude coverage of the treatments and therapies when needed for habilitative reasons, despite the fact that the only major difference between the provision of such therapies to a child is the triggering set of factors for their provision (i.e., attainment and maintenance, versus restoration, of function). The result of these exclusionary techniques has been denial of access to otherwise-covered therapies in the case of children (and adults) who need treatment to attain and maintain health and avert functional loss.

Numerous exclusionary tools come into play; typically these tools are used in combination with one another. One type of tool is to embed treatment exclusions directly into the contractual terms of coverage. For example, health plan documents might define speech therapy as care furnished by a licensed speech therapist when medically necessary to "restore" speech.[6] Another tool involves the exclusion of certain treatment settings from coverage; an example would be to insert a contractual "educational" exclusion that bars otherwise-covered treatments when furnished in school or child care settings as part of an overall child development program,[7] even in cases in which the treatment is furnished by a licensed health care professional. A third type of exclusionary technique would be use of a medical necessity

[4] National Conference of State Legislatures, *Insurance Coverage for Autism* (August 2012) http://www.ncsl.org/issues-research/health/autism-and-insurance-coverage-state-laws.aspx (Accessed online, May 4, 2013)

[5] Institute of Medicine, *Essential Health Benefits: Balancing Coverage and Costs* (National Academy Press, 2011), p. 61.

[6] See, e.g., *Bedrick v Prudential Insurance Co*. 137 F. 3d 1253 (4th Cir., 1994) (speech therapy limited to treatments necessary to "restore" speech and therefore denied to child with cerebral palsy)

[7] See, *Mondry v American Family Mutual Ins. Co.* No. 07-1109 (7th Cir., 2009). In 1984, Medicaid was amended to stop this type of service denial in the case of children receiving covered therapies as part of individualized plans under the Individuals with Disabilities Education Act (IDEA)

standard that allows payment for covered therapies only in cases in which the purpose of the treatment is to recover lost function.[8] A fourth type of tool is the use of internal practice guidelines, which guide individual determinations of medical necessity in particular cases, that advise against interventions in the case of children with developmental disabilities, for whom such interventions are to be considered educational in nature, with no hope of health improvement.[9]

Medicaid and CHIP

As a program designed for impoverished families, and children and adults with disabilities, Medicaid historically has operated in a fashion completely distinct from the principles that guide the types of exclusions of long term treatments for chronic physical and mental conditions that characterize commercial coverage. For this reason, Medicaid's distinct qualities are apparent not only in the populations entitled to coverage but in the level of coverage to which beneficiaries are entitled, especially in the case of children.

Medicaid consists of both required and optional services, and as a general matter, federal law bars states from discriminating on the basis of diagnosis in coverage of required services.[10] This means that Medicaid prohibits states from withholding otherwise covered treatments that fall within required services classes simply because a condition was present at birth as opposed to developing later in life.

Moreover, where children are concerned, no service class falling within the federal definition of "medical assistance" is classified as optional; instead, all services are required services. This special coverage standard is the result of Medicaid's special early and periodic screening, diagnosis and treatment (EPSDT) benefit, which covers individuals from birth to age 21. Part of Medicaid since 1967 and expanded significantly by Congress in 1989, EPSDT offers not only broad preventive benefits but also coverage of all medically necessary treatments and services falling within any of the covered classes of services that together define the concept of "medical assistance." Furthermore, the definition of EPSDT itself adds to the power of its coverage requirements, since the term "early" in the EPSDT statute modifies not only "screening" but also "diagnosis and treatment."[11]

As a result, EPSDT effectively creates a singular coverage standard that entitles children to the broadest possible range of treatments and services (without cost-sharing) at the earliest possible point at which the need for treatment is determined. Finally, EPSDT establishes a medical necessity test that turns on whether a treatment is necessary to "ameliorate" any "physical or mental health condition," thereby eliminating any distinction between physical and mental conditions or between conditions that are present at birth or early infancy as opposed to being subsequently acquired.

In 2006, Congress amended Medicaid to enable states to substitute a more limited "benchmark" benefit design (pegged to the commercial insurance market) in place of traditional Medicaid coverage for certain populations.[12]

[8] See *Bedrick*, supra, note 4.
[9] Id.
[10] 42 C.F. R. §440.230(b)

[11] 42 U.S.C. §§1396d(a)(4)(B) and (r)
[12] §1937 of the Social Security Act, added by the Deficit Reduction Act of 2005.

(The 2006 benchmark amendment reflects both a state option to adopt a commercially oriented benefit design as well as state flexibility to buy such commercial designs from sellers of "benchmark plans.") The 2006 benchmark amendments thus were designed to pave the way to a revision of Medicaid's traditional benefit design in ways that would pull it closer to commercial norms, with their limited coverage of long term treatments for chronic physical, mental, and developmental conditions. At the same time however, the 2006 amendments also preserved the full EPSDT benefit package for children enrolled in benchmark plans.[13] Thus, even in the case of children enrolled in Medicaid benchmark plans, the full EPSDT benefit package remains the coverage standard.

The Children's Health Insurance Program affords states far greater discretion in defining the amount, duration, and scope of covered services. Under CHIP, habilitative services coverage remains a state option in the case of separately administered CHIP plans. Because the EHB provisions do not apply to state CHIP plans, habilitative services remain a state CHIP option in the wake of the ACA.

The Affordable Care Act

The Affordable Care Act transforms the market for private health insurance. However, the scope of the transformation varies depending on which segment of the insurance market is in focus. Certain ACA amendments apply to the private coverage market as a whole, while others, such as the EHB provisions, target the state-regulated individual and small group health insurance market. Furthermore, as discussed below, the ACA cross-walks (that is, applies) the EHB provisions to the Medicaid benchmark statute in order to ensure going forward that states' benchmark plans meet all EHB requirements.

Of course, the ACA's EHB provisions are of special importance to the Health Insurance Marketplace (formerly termed Exchanges, consistent with the Act's statutory terminology). This is because in order to be certified as "Qualified Health Plans" (the type of plan sold in the Marketplaces), issuers must demonstrate that their QHPs cover all essential health benefits in accordance with federal and state requirements. The ACA exempts "grandfathered" plans[14] from nearly all of the general market reforms, as well as the EHB coverage requirements. But the test of grandfathered status is sufficiently stringent so that the proportion of plans that fall into this special exemption category is expected to decline significantly with time. [15]

Key market reforms generally applicable to all non-grandfathered plans sold in the individual or group markets, whether fully insured or self-insured

Certain of the ACA's general market-wide insurance reforms are especially relevant to a discussion of the EHB provisions because they address the basic question of access to coverage among children and adults with disabilities:

- *A bar against lifetime and annual coverage limits.* The Act bars lifetime and annual limits on coverage.[16] Prior to 2014, the Act

[13] §1937(a)(1)(A)(ii)

[14] PPACA §1251

[15] Healthcare.Gov offers a clear explanation of which protections do and do not apply to grandfathered plans. http://www.healthcare.gov/law/features/rights/grandfathered-plans/ (Accessed online May 5, 2013)

[16] PHSA §2711 as added by PPACA §1001

allows certain restricted annual limits on benefits and services falling within the "essential health benefits" category.[17] Thus, to the extent that a health plan of any size offers habilitative services, coverage cannot be subject to either annual or lifetime limits. (Grandfathered plans are subject to the bar against lifetime limits.)

- *Coverage of preventive services.* The Act requires coverage of certain preventive services including services for infants, children and adolescents that are "evidence-informed preventive care and screenings provided for in comprehensive guidelines" issued by the Health Resources and Services Administration (HRSA).[18] HRSA guidelines[19] encompass 26 separate preventive services including numerous screening procedures used to identify children whose health conditions make them candidates for habilitative treatment.

- *Uniform explanations of coverage.* The Act requires all health plans to use uniform explanation of coverage documents and standardized definitions.[20] The Act's uniform explanation of coverage documents do not bind any plan to coverage of the subject matter as described; (in other words, actual coverage still depends on the terms of the plan itself). Nonetheless, the uniform explanation of coverage materials incorporate the NAIC habilitative services definition described earlier ("health care services that help a person keep, learn or improve skills and functioning for daily living").

- *Guaranteed issue and renewal, and a bar against pre-existing condition exclusions or discrimination based on health status.* The Act requires all plans to make coverage available regardless of health status.[21] Furthermore the Act bars the use of pre-existing condition exclusions[22] or other forms of discrimination (such as pricing) that are based on health status.[23]

The EHB Requirements

The EHB provisions of the ACA designate 10 mandatory benefit classes, one of which is "rehabilitative and habilitative services and devices."[24] As noted, the EHB provisions apply to all insurance products sold in the individual and small group markets. The provisions also apply to Medicaid "benchmark" plans (renamed "Alternative Benefit Plans [ABPs]" by the Centers for Medicare and Medicaid Services in proposed rules issued in January 2013). As a result, the EHB amendments effectively raise the bar not only for private insurance but also for Medicaid benchmark plans (now renamed ABPs) that will enroll newly eligible adults ages 21 and older[25] as well as certain children, at state option. (Recall, as previously discussed, however, that individuals enrolled in benchmark

[17] PPHSA §2711(a)(2) as added by PPACA §1001
[18] PHSA §2713(a)(3)
[19] http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html#CoveredPreventiveServicesforChildren
[20] PHSA §2715, added by PPACA §1001

[21] PHSA §2702, added by PPACA §1201
[22] PHSA§2704, added by PPACA §1201
[23] Id.
[24] The 10 categories consist of ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services including oral and vision care. PPACA §1302(b)(1)
[25] 78 Fed. Reg. 4594-4724. See discussion of EHB coverage through alternative benefit plans, 78 Fed. Reg. 4629-4631.

plans and under age 21 remain entitled to the full EPSDT benefit, a coverage guarantee that the ACA does not alter. It is also important to note that young adults entitled to Medicaid on the basis of their status as former foster care children remain exempt from the arguably more limited benchmark rules and entitled to traditional Medicaid coverage, which may include richer benefits for serious and chronic physical and mental health conditions).[26]

Thus, as the Table below illustrates, children who are entitled to Medicaid remain fully entitled to EPSDT, regardless of whether their coverage is effectuated through traditional fee-for-service arrangements, traditional Medicaid managed care arrangements, or through benchmark/ABP arrangements, or even through enrollment in a Qualified Health Plan (QHP) purchased by a state Medicaid program in the Health Insurance Marketplace.[27] For this reason, the habilitative coverage component of the EHB requirement does not directly affect Medicaid-enrolled individuals under 21.

But in the case of private health insurance, the EHB requirement is far-reaching for the millions of children expected to be enrolled in plans sold in the individual and small group markets, particularly those plans (i.e., certified Qualified Health Plans) sold inside the Health Insurance Marketplace. Particularly great interest has been shown in the question of how the EHB requirements will affect coverage obtained through the Health Insurance Marketplace, since it is this segment of the insurance market in which individuals and families, as well as small low-wage employers, will qualify for subsidization through premium tax credits (and cost-sharing assistance in the case of individuals and families).

The EHB Statutory Provisions

As noted, the EHB statute sets forth 10 broad benefit categories, including habilitative and rehabilitative services and devices, and directs the Secretary to define the EHB package. The statute further provides that in carrying out her implementation responsibilities, the Secretary must take into account certain "considerations," three of which bear directly on habilitative services coverage: First, in fashioning the package, the Secretary must balance the health care needs of a "diverse" population, including children. Second, the Secretary must "not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life." Third, the Secretary must ensure that health benefits established as essential [will] not be subject to denial . . . on the basis of individuals' present or predicted disability. . ."[28]

In addition to describing certain covered EHB classes and establishing certain

[26] Social Security Act §1937(a)(2)(B)(viii), as amended by PPACA §2004

[27] Since Medicaid's enactment, states have had the option to cover beneficiaries by buying private insurance coverage. This option is now codified at §1905 of the Social Security Act. Some states, such as Arkansas, are considering using the purchase of Qualified Health Plans sold in the Marketplace to cover some portion of their newly eligible population. Although the Arkansas model appears at this point to be limited to adults, there is no reason why a state could not also buy QHP coverage for families with children. See CMS, Medicaid and the Affordable Care Act: Premium Assistance http://www.healthreformgps.org/wp-content/uploads/medicaid-premium-assistance-3-29.pdf (March 29, 2013). See generally, Sara Rosenbaum for Healthreform GPS for a discussion of Medicaid premium support http://www.healthreformgps.org/resources/using-medicaid-funds-to-buy-qualified-health-plan-coverage-for-medicaid-beneficiaries/ (Accessed online May 5, 2013)

[28] PPACA §1302(b)(4)

"considerations," the statute also defines EHBs in terms of their actuarial value. This definition of EHBs in relation to their actuarial value as well as their specific terms of coverage is significant, as discussed below, because of its implications for the practice of benefit substitution.

Another key matter in examining the implementation of the habilitative services component of the EHB package is its interaction with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Federal regulations implementing MHPAEA[29] interpret the Act as applying to both quantitative (e.g., the number of allowable visits) and non-quantitative (e.g., medical necessity, medical management practices) treatment limits. MHPAEA applies to all employer group plans with 50 or more full-time employees, as well as to QHPs of any size sold in the Health Insurance Marketplace.[30] As a result, understanding how MHPAEA relates to any particular EHB class becomes a significant factor in regulating the practices of both QHPs as well as health plans sold in the small group market.

The Secretary's Approach to Implementation

In implementing the EHB provisions, the Secretary has elected to delegate the power to define EHBs to both states and insurers, at least in the initial implementation years. Recognizing the extent to which U.S. law emphasizes the role of states in the regulation of insurance – an emphasis that has long distinguished the U.S. insurance market and that continues under the ACA – the Secretary has taken an exceptionally broad approach to defining the meaning and scope of EHBs. The EHB regulations effectively delegate the key decisions to states and to the health insurance industry itself, which has long enjoyed considerable discretion to shape coverage design.[31]

The final rules, released in February 2013, [32] were presaged by an *Essential Health Benefits Bulletin* released in December 2011,[33] which laid out a highly deferential approach to implementing the provisions. The deferential approach set forth in the *Bulletin*, and carried over into the final rules, reflects the Administration's view that the concept of keeping and maintaining functioning is "virtually unknown in commercial insurance... " Thus, despite the fact that the same collection of therapies used in rehabilitative treatment (with which, as the *Bulletin* acknowledged, insurers have extensive experience) form the basis of the therapeutic approaches used in habilitative treatment, the *Bulletin* instead focused on the fact that where habilitative care is concerned, the focus is "on creating skills and functions" as opposed to "restoring skills and function" in the case of rehabilitation.[34] For this reason, the Bulletin concluded, issuers needed exceptionally broad latitude where implementation of habilitative coverage is concerned.

Employing this "virtually unknown" rationale, the Bulletin lays out two options to covering habilitative services in cases in which a state elects not to define the scope of the term. Under the first option, insurers may offer habilitative

[29] 75 Fed. Reg. 5410-5451 (Feb 10, 2010)
[30] PPACA §1311(i)

[31] See, generally, Sara Rosenbaum and David Frankford et al., *Law and the American Health Care System* (2d ed., 2012) (Foundation Press, NY, NY)
[32] 78 Fed. Reg. 12834 (February 25, 2013)
[33] http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf (accessed online, May 5, 2013)
[34] Essential Health Benefits Bulletin at p. 11.

services "at parity" with rehabilitation; that is, they may elect to cover the same range of physical, mental, cognition, and other therapies available through rehabilitative coverage, simply substituting a habilitative-related test of coverage (i.e., coverage is available when the treatments are necessary to attain and maintain functional skills as opposed to restoring them). Alternatively – and highly significantly – the *Bulletin* permits issuers on a "transitional basis" to "decide which habilitative services to cover" and report their coverage to HHS.[35]

The final EHB rule preserves the *Bulletin's* construct, by establishing a multi-pronged approach to habilitative services coverage in the EHB-governed market. As a threshold matter – and reflecting the deferential standard that succeeding Administrations have taken to state regulation of insurers ever since the 1996 enactment of the Health Insurance Portability and Accountability Act (HIPAA) – the regulations provide that states "may" determine the meaning and scope of habilitative services if their "base benchmark plan" (which is the starting point for building the essential health benefits package) does not already contain a definition.[36]

The regulations then proceed to lay out what might be thought of as the federal default approach in the event that the state's final EHB benchmark does not include a definition of habilitative services. Under this "default" approach, the two coverage options presented in the *Bulletin* are incorporated into the rules. That is, an issuer either may use a "parity" approach to habilitative coverage or it may determine the meaning and scope of habilitative coverage and report it to HHS.[37]

At this point, two other crucial aspects of the final EHB rule come into play. The first is how the final rule implements the bar against discrimination against persons with disabilities, as well as the requirement that the final package reflect the needs of a diverse population. The final rule [38] simply repeats the terms of the statute and does not amplify on their meaning or apply the considerations to specific cases (such as how the Administration expects that issuers are to balance coverage of rehabilitative services for adults with habilitative services for children and adults with developmental disabilities).

The second crucial aspect of the final EHB rule has to do with the issue of substitution, that is, the discretion of insurers to substitute one set of covered items and treatments for another, as long as the package containing the substituted benefits is the actuarial equivalent of the EHB benchmark. The final rule allows states to bar substitution. But in the absence of a state bar, the rule permits issuers to substitute services but only within the same benefit class. Since rehabilitative and habilitative services fall within the same benefit class,[39] this presumably means that in selecting between the two habilitative services coverage options under the rule (i.e., parity versus insurer-defined level of coverage), insurers may offer a lesser scope of habilitative coverage in favor of a richer rehabilitative benefit package. Such a coverage design strategy may be highly desirable in a QHP marketplace that is expected to attract millions of older adults in poor health.

[35] Id.
[36] 45 C.F.R. §156.110(f)
[37] 45 C.F.R. §156.115 (a)(5)(i) and (ii)
[38] 45 C.F.R. §156.125(a)
[39] PPACA §1302 groups habilitative and rehabilitative services together into a single benefit grouping.

Finally, it is important to note that in the context of non-discrimination, the final EHB rule does not address the interaction of habilitative coverage under the EHB package with MHPAEA.

In sum, the EHB regulations establish a tiering approach to habilitative services coverage policy. In the first tier, the federal government, deferring to the primary role of states in the regulation of insurance, will look to state law. If a state standard is absent – that is, if the state elects not to define the meaning and scope of habilitative coverage, then the second tier commences. Under this tier, insurers would be free to use one of two approaches under the federal default standard as laid out in the final EHB rules. Under the first approach the insurer would offer habilitative coverage at parity with rehabilitative coverage. Under the second, the issuer would fashion a habilitative benefit and report on it. Under the substitution rule, and in the absence of a state prohibition to the contrary, the habilitative benefit could be lessened in favor of a richer rehabilitative services benefit.

A series of blog posts[40] at the Statereforum® website maintained by the National Academy for State Health Policy suggest that some states have begun to develop approaches to habilitative services coverage. As one might expect, these approaches run the gamut, from parity to complete or partial deference to issuers (for example, allowing issuers to design habilitative services coverage generally but requiring them to cover at least some level of habilitative services for children with autism spectrum disorders, presumably reflecting underlying state benefit mandates).

The Approach Taken by the Office of Personnel Management to Essential Health Benefits

The federal Office of Personnel Management (OPM) oversees the QHP certification process in the case of multi-state QHPs. In the case of habilitative services, OPM has taken a strikingly different approach that suggests far less deference to the insurance industry. As is the case with the HHS regulations, OPM will require issuers to follow a state's definition of habilitative services where the state provides a definition. But where the state does not define the coverage, the OPM rule indicates that the agency "may determine what habilitative services and devices are to be included in that EHB-benchmark plan."[41] Thus, unlike HHS, OPM leaves the door open to a potentially more directive approach to defining habilitative services. With respect to the issue of benefit substitution, OPM specifies that an issuer must "comply with any state standards relating to substitution of benchmark benefits or standard benefit designs."[42] Whether, in the absence of a state bar against substitution, OPM in fact will permit substitution within the habilitative/rehabilitative coverage class is not clear.

The interaction of the EHB regulations across public and private insurance markets can be seen in the Table below.

Discussion

This analysis underscores that states remain the

[40] http://www.statereforum.org/search/solr/habilitative%20benefits (Accessed online May 5, 2013)

[41] 5 C.F.R. §800.105(c)(3)

[42] 5 C.F.R. §800.105(b)(3)

first-level decision point where defining the meaning and scope of EHBs is concerned. As such, two possible avenues to a state definition exist. The first is state benefit mandates in effect as of December 31, 2011, which the federal regulation incorporates into the final EHB rule. To the extent that states mandated one or more types of habilitative treatment coverage as of that date, the mandate presumably would apply unless amended or altered in state law. But in many states, the benefit mandate may be limited to certain diagnoses and certain treatments, in contrast to rehabilitative coverage, which typically pertains to a wide array of physical and mental health/addiction disorder conditions for which treatments aimed at aiding recovery are appropriate.

At the same time, as the federal regulations underscore, states retain the primary role in defining the meaning of the federal habilitative services coverage standard, regardless of their own, separate state mandates. As the Statereforum® materials suggest, at least some states are moving to implement the habilitative coverage provisions of the EHB amendments separate and apart from whatever their pre-existing state law benefit mandates may specify. For example, some states already have indicated that they expect issuers to maintain a "parity" approach where habilitative/rehabilitative services are concerned. Other states already have indicated that in the absence of a specific state benefit mandate, issuers will have the discretion to define the habilitative benefit. In the absence of a bar against benefit substitution, this would permit a state issuer to use a more restrictive approach to habilitative treatment coverage, limiting coverage to certain conditions, certain treatment settings, and certain therapies that collectively offer a narrower range of coverage than that available when the focus is on rehabilitation as opposed to habilitation.

In states that are considering defining habilitative treatment coverage rather than defaulting to the federal standard or parity or issuer definition, a number of considerations arise.

Defining habilitative treatment. The NAIC definition ("health care services that help a person keep, learn or improve skills and functioning for daily living") offers the important benefit of having been adopted and endorsed by the NAIC, whose model laws and policies, as noted above, are considered authoritative in the field of insurance regulation. The definition implicitly, yet importantly, reflects a consensus by an authoritative body that such a definition can be implemented by the industry in terms of coverage design, coverage determination, and coverage pricing, all key considerations.

The applicable medical necessity standard and medical management considerations. Under the NAIC definition, a treatment or service would be considered medically necessary if the intervention is necessary to help the individual keep, learn, or improve skills and functioning for daily living. This scope appears to be consistent with the clinical underpinnings of habilitative services. Coverage would not be confined to "attainment" situations (i.e., learn) but would also preserve access to coverage where the intervention is needed to maintain (i.e., keep) skills and functions. The one notable consideration that does not fit neatly into the NAIC definition but that would be relevant to coverage decision-making is whether the treatment is needed to avert deterioration,

although even here, the concept of "keep" arguably encompasses both maintaining and averting loss. Adoption of the NAIC definition of habilitative services with appropriate accompanying indications of policy intent presumably would ensure that the term "keep" is understood as addressing not only maintenance but also the avoidance of loss of functioning.

Limitations and exclusions. An important issue in habilitation is the treatment settings in which otherwise covered services will be recognized. In the case of adults receiving either habilitative or rehabilitative services, the location of care may be either an inpatient or outpatient clinical setting. In the case of children, the service location might be a comprehensive day program or school setting, where, during the day of education or child care, a child in need of habilitative treatments receives additional or extra therapies by licensed clinical health professionals. In these situations an important consideration is whether, as long as the health care professional meets applicable state licensure and certification requirements and is furnishing a covered benefit (e.g., speech therapy, physical therapy, therapy to improve cognition or socialization), issuers will have the discretion to exclude otherwise covered treatment because it is received in an educational or social setting.

Substitution versus parity. As the federal regulations underscore, substitution is not uncommon in the commercial insurance market. Because habilitative and rehabilitative services arguably fall within a single benefit class, it would be possible for an insurer to limit habilitative coverage in order to expand rehabilitative coverage. If this result is not desired, then state law would need to explicitly bar substitution within the benefit classes, as so indicated by the federal rule.

Interaction with mental health parity requirements. As noted, mental health parity requirements apply to both QHPs sold in Health Insurance Marketplaces and to small group plans sold outside the Marketplace and covering 50 or more full-time employees. In order to clarify the relationship between the MHPAEA requirements and habilitative services, it would be helpful for a state's habilitative coverage policy to specify the application of MHPAEA in the habilitative treatment context, with respect to both quantitative and non-quantitative treatment limits. By specifying the application of MHPAEA, state habilitative coverage policy would underline the fact that on matters having to do with coverage design or management, MHPAEA prohibits insurers from treating children with mental disabilities in a manner different from those with physical disabilities. Examples of key design and management aspects of insurance where MHPAEA could make a decisive difference would be differentials in the use of treatment plans that require ongoing insurer re-certification, the use of fixed practice guidelines that specify absolute coverage limits (as opposed to softer limits that defer to clinical judgment), differentials in quantitative treatment limits, or differential cost-sharing requirements.

Conclusion

Ultimately, the federal government may use the results of the information it gains in overseeing the EHB coverage market – both inside and outside the Health Insurance Marketplace – to move in the direction of a more uniform

national standard. Because the information on habilitative services coverage proposed by QHP bidders is not public, it is not possible to know with certainty how many issuers are proposing to use a parity approach as opposed to an alternate approach that also allows substitution within the habilitative/rehabilitative benefit class. As QHPs come on line in both federally administered and state-based Marketplaces, the task of understanding the current state of habilitative coverage in the EHB market will be eased. It also will be important to determine whether coverage differences emerge in that portion of the EHB market that lies outside of the Health Insurance Marketplace and that involves direct sales by agents and brokers. Also of importance will be how OPM approaches the question of habilitative services coverage in the case of issuers that do not operate under state coverage standards. The OPM regulations at least hint at the notion that the agency is considering more decisive and uniform habilitative coverage standards in its negotiations with issuers, but, of course, it is still too early to tell. In the meantime, state EHB coverage policy offers the crucial starting point for habilitative services coverage.

Sara Rosenbaum is the Harold and Jane Hirsh Professor of Health Law and Policy at the George Washington University School of Public Health and Health Services.

Table 1: Coverage of Habilitative Services for Children Across Multiple Insurance Markets and Plan Types

Market and Plan Type	Habilitation Coverage Standard
Medicaid and CHIP	
Fee-for-service	Under EPSDT, children are entitled to all federally recognized Medicaid benefits necessary to diagnose and ameliorate physical and mental health conditions
Traditional managed care[43]	Same coverage standard
Alternative benefit plans[44]	Same coverage standard
Premium assistance for qualified health plan (QHP) coverage[45]	Same coverage standard
Separately administered CHIP plans	State defines coverage
Essential Health Benefit (EHB)-Governed Markets (Individual policies and Small Group Plans)	
Inside the Health Insurance Marketplace for Qualified Health Plans (QHPs)[46]	
State-based Marketplaces	State sets the standard or default to federal standard at state option[47]
Federally facilitated Marketplaces	State standard applies; if none, then default to federal standard (habilitation/rehabilitation parity or issuer-designed standard)[48]
OMB-certified multi-state QHPs	State standard applies; if none, then OPM negotiates with the QHP issuer.
Outside the Health Insurance Marketplace	State sets the standard; if none, federal default standard applies
Large Employer Groups, Insured or Self-Insured	At the discretion of the group sponsor and the issuer or plan administrator: EHB standard does not apply

[43] Social Security Act §1932
[44] Social Security Act §1937
[45] Social Security Act §1905, with or without an accompanying §1115 demonstration waiver
[46] Formerly termed Exchanges
[47] 45 C.F.R. §156.110(f)
[48] 45 C.F.R. §156.115(a)(5)(i) and (ii)

THE COMMONWEALTH FUND

May 2012

Issues in International Health Policy

Explaining High Health Care Spending in the United States: An International Comparison of Supply, Utilization, Prices, and Quality

David A. Squires
The Commonwealth Fund

ABSTRACT: This analysis uses data from the Organization for Economic Cooperation and Development and other sources to compare health care spending, supply, utilization, prices, and quality in 13 industrialized countries: Australia, Canada, Denmark, France, Germany, Japan, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States. The U.S. spends far more on health care than any other country. However this high spending cannot be attributed to higher income, an older population, or greater supply or utilization of hospitals and doctors. Instead, the findings suggest the higher spending is more likely due to higher prices and perhaps more readily accessible technology and greater obesity. Health care quality in the U.S. varies and is not notably superior to the far less expensive systems in the other study countries. Of the countries studied, Japan has the lowest health spending, which it achieves primarily through aggressive price regulation.

★ ★ ★ ★ ★

INTRODUCTION

Health care spending is a key component of any industrialized country's economy. It provides a major source of employment, often for highly skilled workers and in rural areas without other significant industries. In addition, the development of drugs and medical technologies can lead to breakthrough products, innovation hubs, and new markets. Most important, health spending satisfies fundamental individual and social demands for services that bring improved health, greater productivity, and longer lives.

Compared with most other sectors of the economy, a large share of health care is publicly funded. In all industrialized countries, with the exception of the United States, health care affordability is ensured through universal insurance-based or tax-financed systems.[1] In the U.S., public funds contribute to health care through

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

For more information about this study, please contact:

David A. Squires, M.A.
Senior Research Associate
International Program in Health Policy and Innovation
The Commonwealth Fund
ds@cmwf.org

To learn more about new publications when they become available, visit the Fund's Web site and register to receive e-mail alerts.

Commonwealth Fund pub. 1595
Vol. 10

insurance programs like Medicare and Medicaid, as well as through tax policy that supports employer-sponsored health insurance, delivery systems like the Veterans Health Administration, and research by the National Institutes of Health. Because of the significant public sector stake in health care, ensuring we receive value for this investment is a compelling social concern.

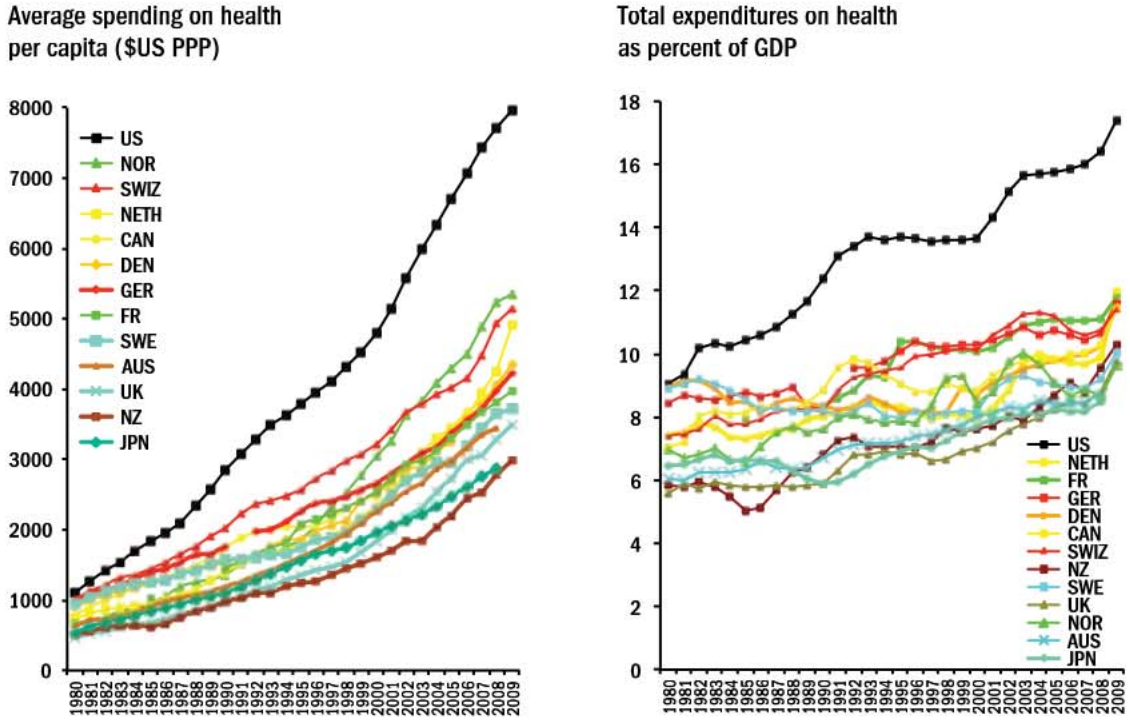
This study updates previous cross-national studies sponsored by The Commonwealth Fund using health data from the Organization for Economic Cooperation and Development (see Methods).[2,3] It compares health care spending, supply, utilization, prices, and quality in 13 industrialized countries: Australia, Canada, Denmark, France, Germany, Japan, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the U.K., and the U.S. The analysis finds that the U.S. spends more than all other countries on health care, but this higher spending cannot be attributed to higher income, an aging population, or greater supply or utilization of hospitals and doctors. Instead, it is more likely that higher spending is largely due to higher prices and perhaps more readily accessible technology and greater obesity. Despite being more expensive, the quality of health care in the U.S. appears to be variable, with better-than-average cancer survival rates, middling in-hospital mortality rates for heart attacks and stroke, and the worst rates of presumably preventable deaths due to asthma and amputations due to diabetes compared with the other study countries. In contrast, Japan, which has the lowest health spending among these countries, controls costs primarily through aggressive price regulation—demonstrating the powerful correlation between health care prices and total spending.

KEY FINDINGS

Health Care Spending in the U.S. Is Far Greater Than in Other Industrialized Countries

As previous studies have shown, health care spending in the U.S. dwarfs that found in any other industrialized country. In 2009, U.S. spending reached nearly $8,000 per capita. The other study countries spent between one-third (Japan and New Zealand) and two-thirds (Switzerland and Norway) as much (Exhibits 1 and 2).[4]

Exhibit 1. International Comparison of Spending on Health, 1980–2009



Note: PPP = Purchasing power parity—an estimate of the exchange rate required to equalize the purchasing power of different currencies, given the prices of goods and services in the countries concerned.
Source: OECD Health Data 2011 (Nov. 2011).

Exhibit 2. Health Spending in Select OECD Countries, 2009

	Population (millions)	GDP per capita[b]	Total health spending		Health spending, by source of financing		
			Per capita[b]	% GDP	Public	Private	Out-of-pocket
Australia	22.0	$39,924	$3,445[a]	8.7%[a]	$2,342[a]	$476[a]	$627[a]
Canada	33.4	$38,230	$4,363	11.4%	$3,081	$646	$636
Denmark	5.5	$37,706	$4,348	11.5%	—	—	—
France	62.6	$33,763	$3,978	11.8%	$3,100	$587	$291
Germany	81.9	$36,328	$4,218	11.6%	$3,242	$424	$552
Japan	127.5	$32,431	$2,878[a]	8.5%[a]	$2,325[a]	$99[a]	$454[a]
Netherlands	16.4	$41,085	$4,914	12.0%	—	—	—
New Zealand	4.3	$28,985	$2,983	10.3%	$2,400	$184	$399
Norway	4.8	$55,730	$5,352	9.6%	$4,501	$43	$808
Sweden	9.3	$37,155	$3,722	10.0%	$3,033	$69	$620
Switzerland	7.7	$45,150	$5,144	11.4%	$3,072	$504	$1,568
United Kingdom	60.9	$35,656	$3,487	9.8%	$2,935	$188	$364
United States	306.7	$45,797	$7,960	17.4%	$3,795	$3,189	$976
OECD Median	***10.7***	***$33,434***	***$3,182***	***9.5%***	***$2,400***	***$193***	***$559***

[a] 2008.
[b] Adjusted for differences in cost of living.
Source: OECD Health Data 2011 (Nov. 2011).

Accounting for differences in national income, the U.S. still far outspent the other countries, dedicating more than 17 percent of its gross domestic product (GDP) to health care compared with 12 percent or less in all other countries. These figures reflect health spending inflation that has rapidly surpassed GDP in recent decades.

While there is a positive correlation between health spending and per capita income in the 34 member countries in the Organization for Economic Cooperation and Development (OECD), the higher spending observed in the U.S. does not seem primarily attributable to greater income. In the wealthiest of the study countries, Norway, health spending accounts for only 9.6 percent of GDP—nearly 8 percentage points less than in the U.S. (Exhibit 2). Based on national income and health spending in other OECD countries, a linear regression would predict that U.S. health spending would be $4,849 per capita or 11 percent of GDP—far less than is actually observed.[5]

Public spending in the U.S. accounted for almost half of all health spending in 2009, whereas in other countries it accounted for between 60 percent (Switzerland) and 84 percent (Norway and the U.K.) However, in terms of spending per capita, only Norway ($4,501) had higher public health care spending than the U.S. ($3,795). In fact, public per capita spending in the U.S. exceeded total per capita health spending in Sweden, the U.K., Australia, New Zealand, and Japan.

U.S. Has Smaller Elderly Population and Fewer Smokers, But Higher Obesity Rates

One potential explanation for the high level of U.S. health care spending is to attribute it to the aging population, as the baby boom generation enters retirement age with correspondingly greater health care needs. However, this theory does not appear to be borne out. While the population is growing older, the U.S. has a relatively young population compared with the other study countries (Exhibit 3). Only 13 percent of the U.S. population was older than 65 in 2009, compared with the OECD median of nearly 16 percent. New Zealand was the only study country with a smaller elderly population than the U.S., whereas more than one-fifth of the populations of Germany and Japan were over 65. Moreover, the proportion of the U.S. population over age 65 has grown relatively slowly in recent years, rising only 0.5 percent since 1999, suggesting that an aging demographic has not been a primary driver of health spending increases over the past decade.

Exhibit 3. Determinants of Health in Select OECD Countries, 2009

	Percent of population over age 65		Tobacco consumption (% population age 15+ who are daily smokers)		Obesity (% population with BMI ≥ 30)	
	1999	2009	1999	2009	1999	2009
Australia	12.3%	13.3%	22.1%[e]	16.6%[b]	21.7%	24.6%[b]
Canada	12.5%	13.9%	23.8%[e]	16.2%	13.6%[c,d]	24.2%[a]
Denmark	14.9%	16.1%	31.0%	19.0%	—	—
France	15.9%	16.7%	28.0%	26.2%[a]	8.2%[c,d]	11.2%[a,c]
Germany	16.1%	20.5%	24.7%	21.9%	11.5%[c]	14.7%[c]
Japan	16.7%	22.7%	33.6%	24.9%	2.8%	3.9%
Netherlands	13.5%	15.2%	27.8%	28.0%	8.7%[c]	11.8%[c]
New Zealand	11.7%	12.8%	26.0%	18.1%[b]	18.8%[e]	26.5%[b]
Norway	15.4%	14.8%	32.0%	21.0%	6%[d,c]	10.0%[a,c]
Sweden	17.3%	17.9%	19.3%	14.3%	8.1%[c]	11.2%[c]
Switzerland	15.2%	17.2%	28.9%[f]	20.4%[b]	6.8%[c,e]	8.1%[b,c]
United Kingdom	15.8%	15.8%	27.0%[e]	21.5%	20.0%	23.0%
United States	12.5%	13.0%	19.2%	16.1%	30.5%[f]	33.8%[a]
OECD Median	***14.5%***	***15.8%***	***26.0%***	***21.5%***	—	—

Note: BMI = body mass index.
[a] 2008.
[b] 2007.
[c] Self-reported data as opposed to directly measured; tends to underestimate.
[d] 1998.
[e] 1997.
[f] 2000.
Source: OECD Health Data 2011 (Nov. 2011).

Lifestyle and behavior are also major determinants of health, which in turn have an impact on health care needs and spending. The OECD reports on several health-related lifestyle and behavioral indicators, including tobacco consumption and obesity. Adults in the U.S. were the least likely to be daily smokers than in all of the study countries except for Sweden. In 2009, 16 percent of U.S. adults were daily smokers compared with the OECD median of 21.5 percent (Exhibit 3). In Japan, France, and the Netherlands, one-quarter or more of the population over age 15 are smokers. Over the past decade, smoking rates have declined in all countries except the Netherlands.

The story is very different for obesity, which is defined as having a body mass index (BMI) equal to or greater than 30. One-third of the U.S. population is obese—higher than the proportion in any OECD country. However, in many countries only self-reported data (rather than direct measurements) are available, which tend to underestimate obesity. Notably, more than one-fifth of the population is also obese in several study countries, including New Zealand (27%), where the prevalence jumped by nearly 8 percentage points over the past decade compared with only 3 percentage points in the U.S. (Exhibit 3).

Higher rates of obesity undoubtedly inflate health spending; one study estimates the medical costs attributable to obesity in the U.S. reached almost 10 percent of all medical spending in 2008.[6] However, the younger population and lower rates of smoking likely have an opposite effect, reducing U.S. health care spending relative to most other countries.

U.S. Has Below-Average Supply and Utilization of Physicians, Hospitals Beds

Another commonly assumed explanation for higher U.S. health care spending is that the utilization or supply of health care services in the U.S. must be greater than in

other countries. OECD data suggest, however, that this assumption is unfounded, at least when it comes to physician and hospital services. There were 2.4 physicians per 1,000 population in the U.S. in 2009, fewer than in all other study countries except Japan. Likewise, patients had fewer doctor consultations in the U.S. (3.9 per capita) than in any other country except Sweden (Exhibit 4).

Hospital supply and use showed similar trends, with the U.S. having fewer hospital beds (2.7 per 1,000 population), shorter lengths of stay for acute care (5.4 days), and fewer discharges (131 per 1,000 population) than the OECD median (Exhibit 4). Exhibit 5, however, shows that hospital stays in the U.S. were far more expensive than in the other study countries, exceeding $18,000 per discharge compared with less than $10,000 in Sweden, Australia, New Zealand, France, and Germany. This could indicate that U.S. hospital stays tend to be more resource-intensive than in other countries or that the prices for hospital services are higher.

Prices for Drugs, Office Visits, and Procedures Are Highest in the U.S.

Exhibit 6 shows prices for selected health services and products to be higher in the U.S.—far higher, in some cases—than in the other study countries. According to an analysis by Gerard Anderson of IMS Health data, U.S. prices for the 30 most-commonly prescribed drugs are one-third higher than in Canada and Germany, and more than double the prices in Australia, France, Netherlands, New Zealand, and the U.K. (Exhibit 6).[7] Notably, prices for generic drugs are lower in the U.S. than in these other countries, whereas prices for brand-name drugs are much higher.

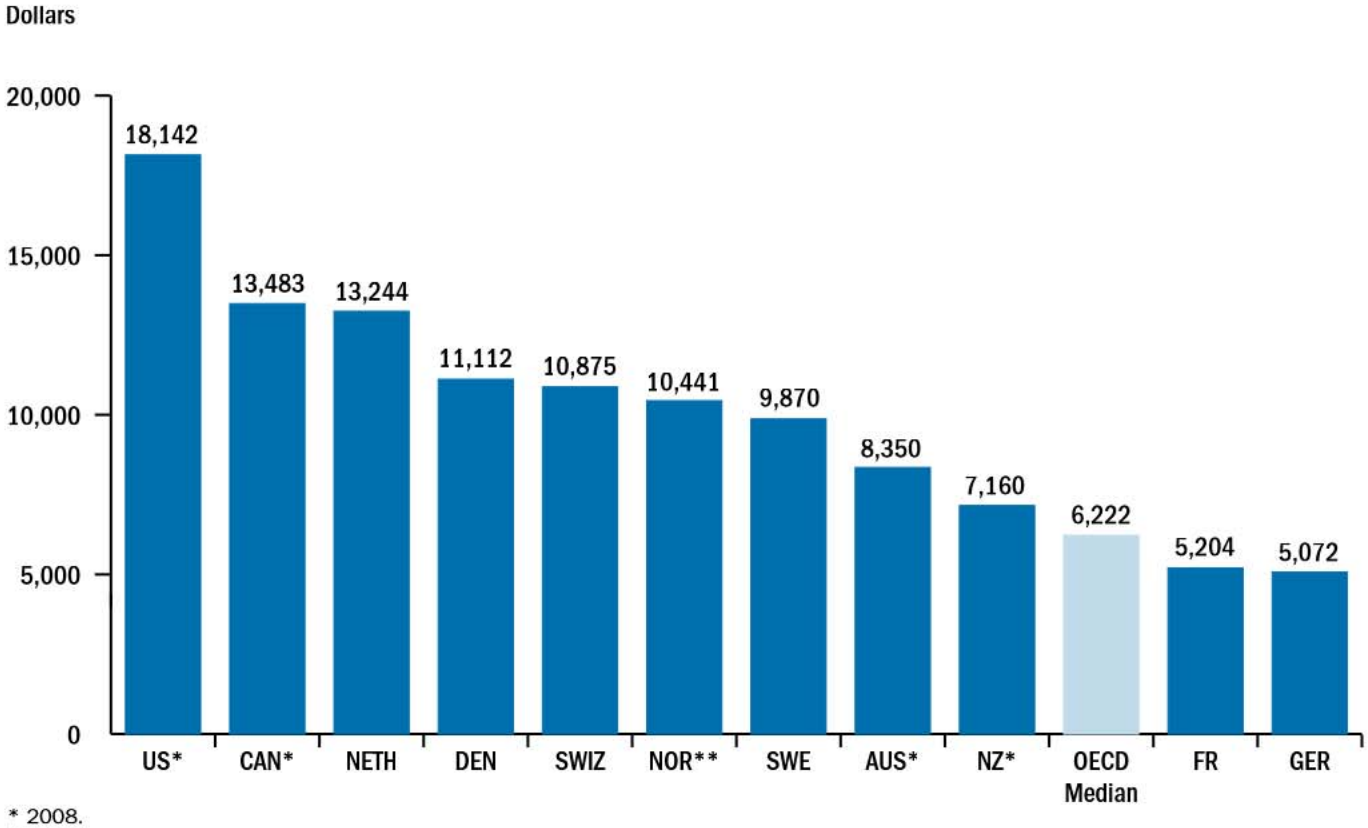
Spending on physician services is an even larger component of total health spending than pharmaceuticals. In an analysis published in *Health Affairs* in 2011, Miriam Laugesen and Sherry Glied found U.S. primary care physicians generally receive higher fees for office visits and orthopedic physicians receive higher fees for hip replacements than in Australia, Canada,

Exhibit 4. Supply and Utilization of Doctors and Hospitals in Select OECD Countries, 2009

	Physician supply and use		Hospital supply and use		
	Practicing physicians per 1,000 population	Doctor consultations per capita	Acute care hospital beds per 1,000 population	Average length of stay for acute care (days)	Hospital discharges per 1,000 population
Australia	3.0[a]	6.5	—	5.9[a]	162[a]
Canada	—	5.5[a]	1.8[a]	7.7[a]	84[a]
Denmark	3.4[a]	4.6	2.9	—	170
France	—	6.9	3.5	5.2	263
Germany	3.6	8.2	5.7	7.5	237
Japan	2.2[a]	13.2[a]	—[d]	—[d]	—[d]
Netherlands	—	5.7	3.1	5.6	117
New Zealand	2.6	4.3[b]	—	5.9[a]	142[a]
Norway	4.0	—	2.4	4.6	177
Sweden	3.7[a]	2.9	2.0	4.5	166
Switzerland	3.8	4.0[b]	3.3	7.5	168
United Kingdom	2.7	5.0	2.7	6.8	138
United States	2.4	3.9[a]	2.7[b]	5.4	131[a]
OECD Median	***3.0***	***6.3***	***3.2***	***5.9***	***160***

[a] 2008.
[b] 2007.
[c] Adjusted for differences in cost of living.
[d] A significant amount of hospital care is dedicated to long-term care in Japan, making cross-national comparison difficult.
Source: OECD Health Data 2011 (Nov. 2011).

Exhibit 5. Hospital Spending per Discharge, 2009
Adjusted for Differences in Cost of Living



* 2008.
** 2007.
Source: OECD Health Data 2011 (Nov. 2011).

Exhibit 6. Drug Prices and Physician Fees in Select OECD Countries

	Prices for 30 most commonly prescribed drugs, 2006–07 (U.S. set at 1.00)[a]			Primary care physician fee for office visits, 2008[b,c]		Orthopedic physician fee for hip replacements, 2008[b,c]	
	Brand name	Generic	*Overall*	Public payer	Private payer	Public payer	Private payer
Australia	0.40	2.57	0.49	$34	$45	$1,046	$1,943
Canada	0.64	1.78	0.77	$59	—	$652	—
France	0.32	2.85	0.44	$32	$34	$674	$1,340
Germany	0.43	3.99	0.76	$46	$104	$1,251	—
Netherlands	0.39	1.96	0.45	—	—	—	—
New Zealand	0.33	0.90	0.34	—	—	—	—
Switzerland	0.51	3.11	0.63	—	—	—	—
United Kingdom	0.46	1.75	0.51	$66	$129	$1,181	$2,160
United States	1.00	1.00	1.00	$60	$133	$1,634	$3,996
Median (countries shown)	***0.43***	***1.96***	***0.51***	***$53***	***$104***	***$1,114***	***$2,052***

[a] Source: Analysis by G. Anderson of IMS Health data.
[b] Adjusted for differences in cost of living.
[c] Source: M.J. Laugesen and S.A. Glied, "Higher Fees Paid to U.S. Physicians Drive Higher Spending for Physician Services Compared to Other Countries," *Health Affairs,* Sept. 2011 30(9):1647–56.

France, Germany, and the U.K. (Exhibit 6).[8] This was true whether the payers were public or private, though in every country private payers paid higher fees than public payers (where data was available). Not surprising, Laugesen and Glied also found that U.S. primary care doctors ($186,582) and particularly orthopedic doctors ($442,450) earned greater income than in the other five countries (Exhibit 7).

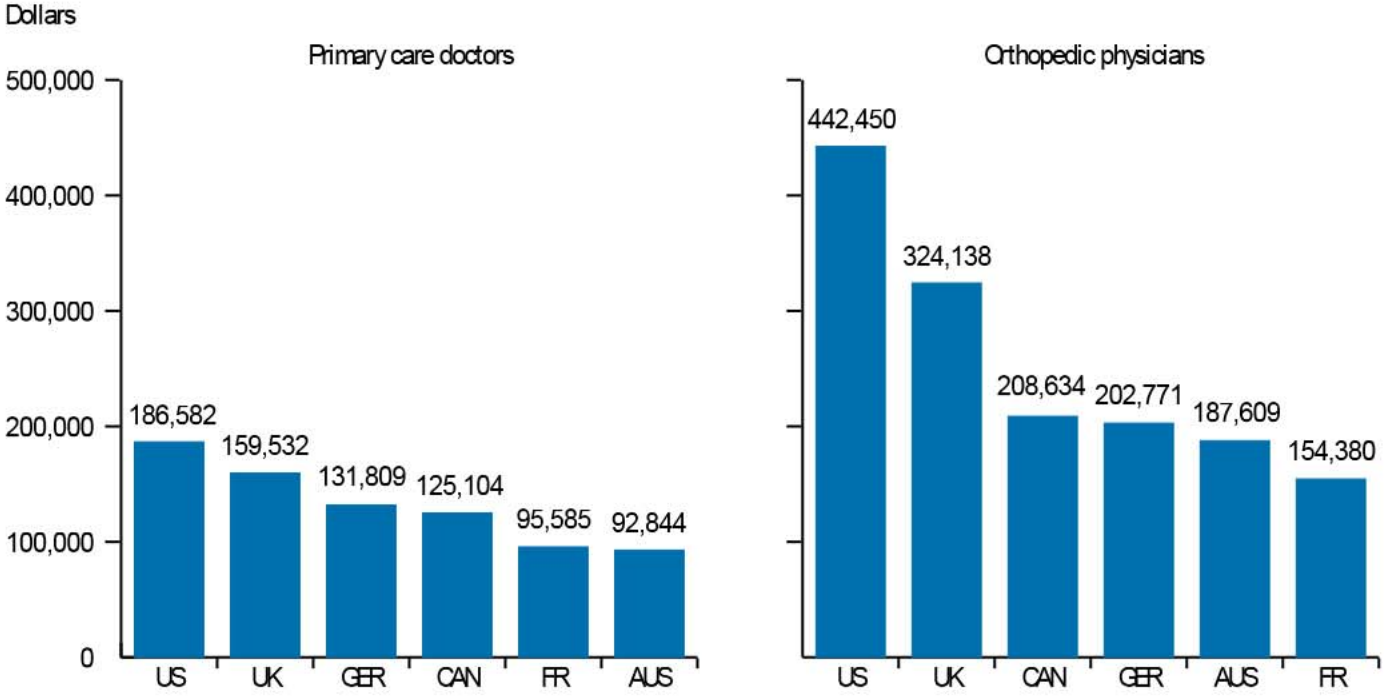
Use of Expensive Medical Technology More Common in the U.S.

The final potential explanation for high U.S. health spending considered in this study is greater use of more expensive medical technology than other countries. The OECD tracks the volume of several types of procedures, including hip and knee replacements—two generally elective procedures that involve expensive medical devices. In 2009, the U.S., along with Germany, performed the most knee replacements (213 per 100,000 population) among the study countries, and 75 percent more knee replacements than the OECD median (122 per 100,000 population). However, the U.S. performed barely more hip replacements than the OECD median, and significantly less than several of the other study countries (Exhibit 8).

The OECD also tracks the supply and utilization of several types of diagnostic imaging devices—important and often costly technologies. Relative to the other study countries where data were available, there were an above-average number of magnetic resonance imaging (MRI) machines (25.9 per million population), computed tomography (CT) scanners (34.3 per million), positron emission tomography (PET) scanners (3.1 per million), and mammographs (40.2 per million) in the U.S. in 2009 (Exhibit 9). Utilization of imaging was also highest in the U.S., with 91.2 MRI exams and 227.9 CT exams per 1,000 population. MRI and CT devices were most prevalent in Japan, though no utilization data were available for that country.

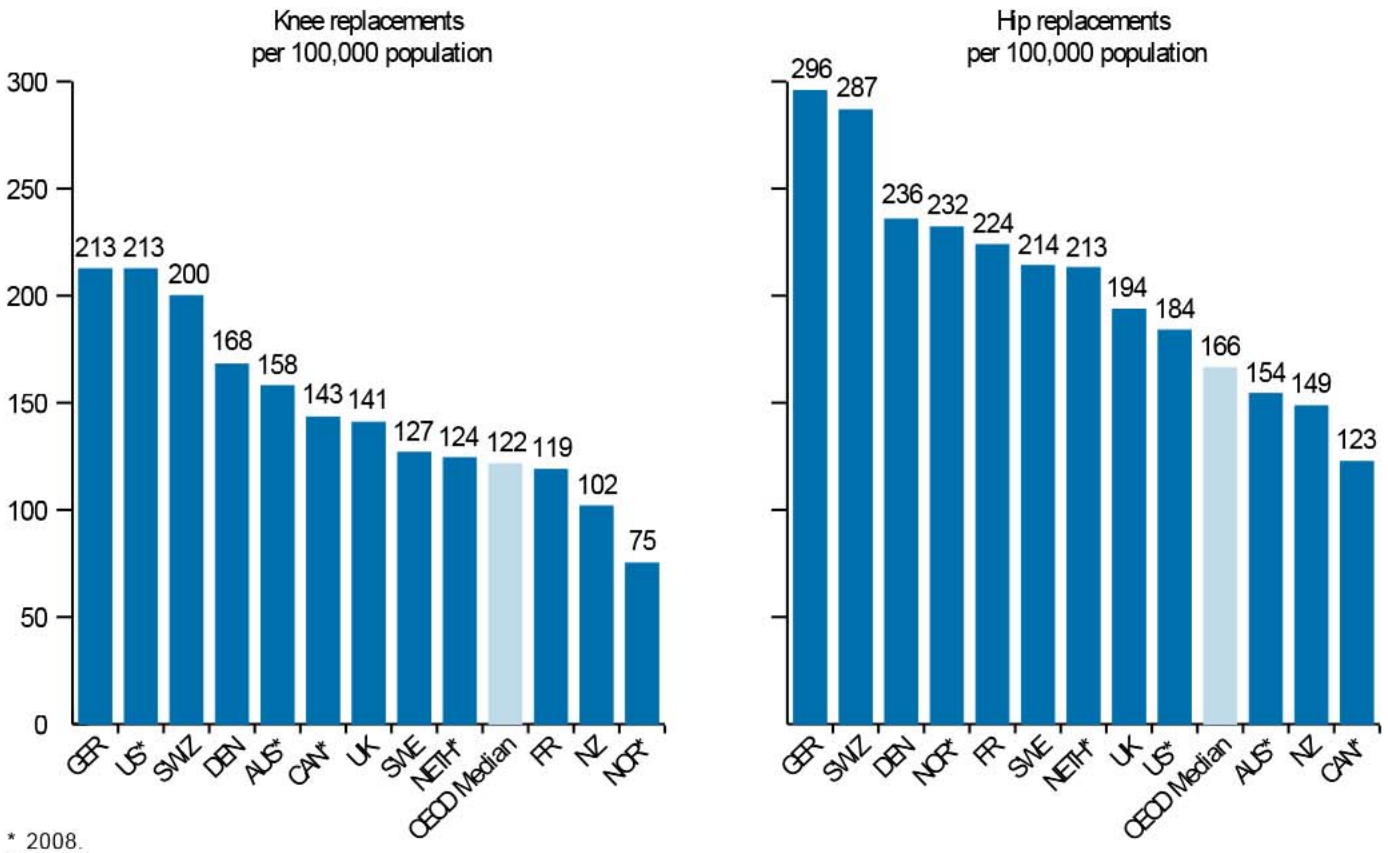
The International Federation of Health Plans—a membership organization of health insurance companies from over 30 countries—issues an annual report tracking

Exhibit 7. Physician Incomes, 2008
Adjusted for Differences in Cost of Living



Source: M. J. Laugesen and S. A. Glied, Higher Fees Paid to U.S. Physicians Drive Higher Spending for Physician Services Compared to Other Countries, Health Affairs, Sept. 2011 30(9):1647 56.

Exhibit 8. Volume of Knee and Hip Replacements, 2009



* 2008.
** 2007.
Source: OECD Health Data 2011 (Nov. 2011).

Exhibit 9. Diagnostic Imaging in Select OECD Countries

	MRI machines			CT scanners			PET scanners	Mammographs
	Devices per million pop., 2009[c]	Exams per 1,000 pop., 2009[c]	MRI scan fees, 2011[d]	Devices per million pop., 2009[c]	Exams per 1,000 pop., 2009[c]	CT scan (head) fees, 2011[d]	Devices per million pop., 2009[c]	Devices per million pop., 2009[c]
Australia	5.9	23.3	—	38.7	93.9	—	1.1	24.3
Canada	8.0	43.0	—	13.9	125.4	$122[e]	1.1	—
Denmark	15.4	37.8[a]	—	23.7	83.8[a]	—	5.6	17.0
France	6.5	55.2	$281	11.1	138.7	$141	0.9	—
Germany	—	—	$599	—	—	$272	—	—
Japan	43.1[a]	—	—	97.3[a]	—	—	3.7[a]	29.7[a]
Netherlands	11.0	43.9	—	11.3	65.7	—	4.5	—
New Zealand	9.7	—	—	14.6	—	—	0.5	26.4
Switzerland	—	—	$903	32.8	—	$319	3.0	33.2
United Kingdom	5.6[a]	—	—	7.4a	—	—	—	9.0
United States	25.9[b]	91.2[b]	$1,080[f]	34.3[b]	227.9[b]	$510[f]	3.1[a]	40.2[a]
Median (countries shown)	***8.9***	***43.0***	—	***15.1***	***122.8***	—	***1.1***	***17.3***

[a] 2008.
[b] 2007.
[c] Source: OECD Health Data 2011 (Nov. 2011).
[d] Source: International Federation of Health Plans, *2011 Comparative Price Report: Medical and Hospital Fees by Country* (London: IFHP, 2011).
[e] Nova Scotia only.
[f] U.S. commercial average.

health care prices around the world.[9] Data from their 2011 report indicate that the U.S. commercial average diagnostic imaging fees ($1,080 for an MRI and $510 for a CT exam) are far higher than what is charged in almost all of the other countries (Exhibit 9). This combination of pervasive medical technology and high prices showcases two potent drivers of U.S. health spending, and a possible explanation for the outsized share of resources we dedicate to health care relative to the rest of the world.

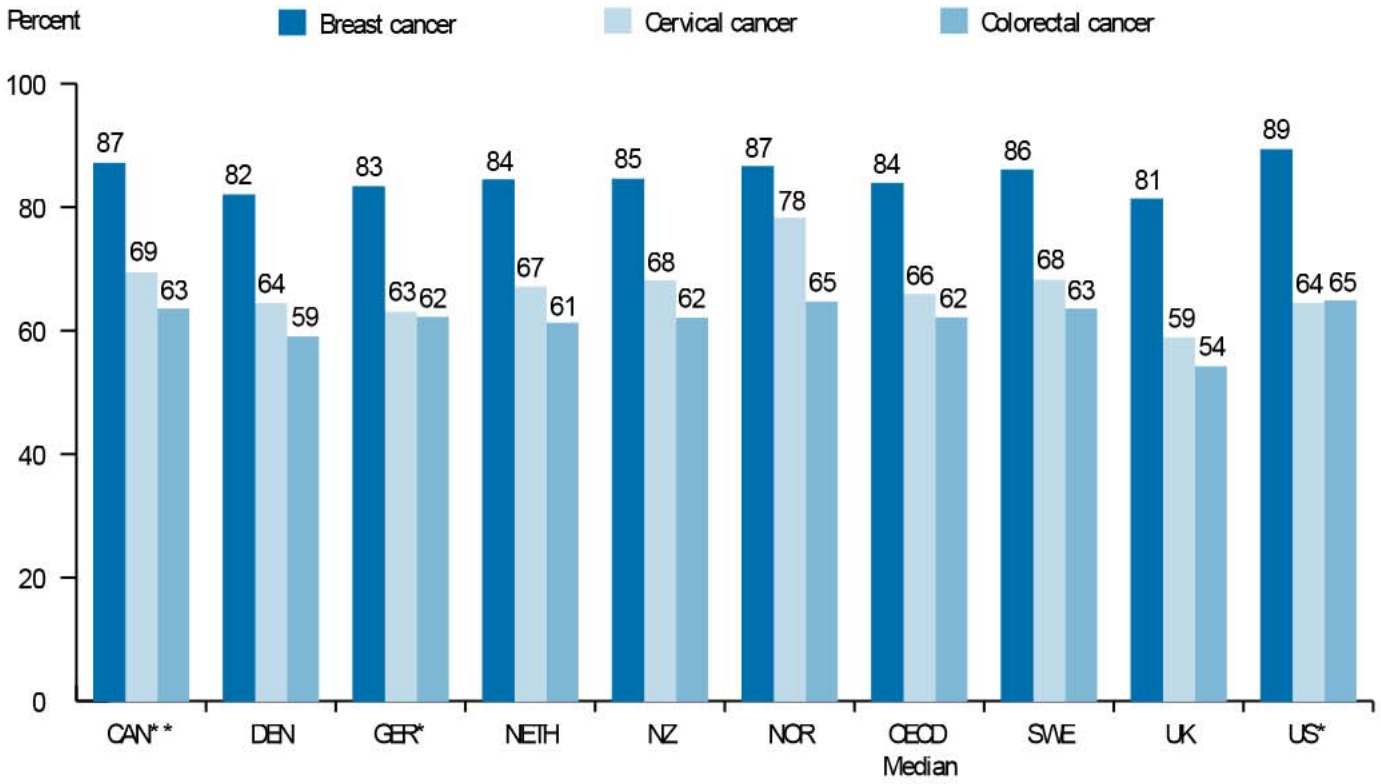
Despite High Health Care Spending, Quality Indicators Show Variable Performance in the U.S.

An array of health care quality indicators included in the 2011 OECD Health Data database provides insight into the performance of each country's health care system. The findings make clear that, despite high costs, quality in the U.S. health care system is variable and not notably superior to the far less expensive systems in the other study countries.

Exhibit 10 shows the five-year survival rates for breast, cervical, and colorectal cancers. The U.S. had the highest survival rates among the study countries for breast cancer (89%) and, along with Norway, for colorectal cancer (65%). However, at 64 percent, the survival rate for cervical cancer in the U.S. was worse than the OECD median (66%), and well below the 78 percent survival rate in Norway—indicating significant room for improvement. Notably, the U.K. had the lowest survival rates for all three forms of cancer.

Exhibit 11 shows rates of potentially preventable mortality due to asthma (for those between ages 5 and 39) and lower-extremity amputations due to diabetes per 100,000 population. On both measures, the U.S. had among the highest rates, suggesting a failure to effectively manage these chronic conditions that make up an increasing share of the disease burden.[10] Exhibit 11 also shows rates of in-hospital fatality rates—that is, the ratio of in-hospital deaths among people admitted with a particular condition—within 30 days of admission for

Exhibit 10. Five-Year Survival Rate for Select Cancers, 2004–2009



Note: Breast and cervical cancer rates are age-standardized; colorectal cancer rates are age–sex standardized.
* 2003–08.
** 2002–07.
Source: OECD Health Data 2011 (Nov. 2011).

Exhibit 11. Quality Indicators in Select OECD Countries, 2009

	Asthma mortality among ages 5 to 39 per 100,000 population	Diabetes lower extremity amputations per 100,000 population	In-hospital fatality rate within 30 days of admission per 100 patients[c]		
			Acute myocardial infarction	Ischemic stroke	Hemorrhagic stroke
Australia	0.13	11.0	3.2	5.7	17.2
Canada	0.17[b]	9.5	3.9	6.3	20.6
Denmark	0.08	18.1	2.3	2.6	16.4
France	—	12.6[b]	—	—	—
Germany	0.17[b]	33.7	6.8	4.0	13.8
Japan	—	—	9.7[a]	1.8[a]	9.7[a]
Netherlands	0.09[a]	12.0[b]	5.3[b]	5.7[b]	22.5[b]
New Zealand	0.43[b]	7.0	3.2	5.4	21.1
Norway	0.27	9.9	2.6	2.8	11.6
Sweden	0.01[a]	5.7	2.9[b]	3.9[b]	12.8
Switzerland	—	7.4[a]	4.5[a]	—	14.8[a]
United Kingdom	0.27	4.8	5.2	6.8	19.3
United States	0.40[b]	32.9[a]	4.3[a]	3.0[a]	21.0[a]
OECD Median	***0.09***	***9.9***	***4.6***	***4.9***	***19.3***

Note: Rates are age–sex standardized.
[a] 2008.
[b] 2007.
[c] Figures do not account for death that occurs outside of the hospital, possibly influencing the ranking for countries, such as the U.S., that have shorter lengths of stay.
Source: OECD Health Data 2011 (Nov. 2011).

acute myocardial infarctions and ischemic and hemorrhagic stroke.[11] U.S. performance on these measures was middling: the fatality rate for acute myocardial infarctions was roughly average in the U.S. (4.3 deaths per 100 patients) compared with the study countries, the rate for ischemic stroke (3.0 deaths per 100 patients) was somewhat better than average, and the rate for hemorrhagic stroke (21.0 deaths per 100 patients) was somewhat worse than average.

DISCUSSION

U.S. health care spending, which reached nearly $8,000 per person annually in 2009, has outpaced GDP growth for the past several decades and far exceeds spending in any other country. The analysis in this brief suggests that this spending cannot be attributed to higher income, an aging population, or greater supply or utilization of hospitals and doctors. Instead, it is more likely that higher spending is largely due to higher prices and perhaps because of more readily accessible technology and greater rates of obesity. Despite being more expensive, the quality of health care in the U.S. does not appear to be notably superior to other industrialized countries.

Such an expensive health system creates an enormous financial strain and can pose a barrier to accessing care. For many U.S. households, health care has become increasingly unaffordable. In 2010, four of 10 adults went without care because of costs and the number of either uninsured or "underinsured" (i.e., people with health coverage that does not adequately protect them from high medical expenses) increased to more than 80 million.[12] A 2007 survey in five states found that difficulty paying medical bills contributed to 62 percent of all bankruptcies, up 50 percent from 2001.[13] For the average worker with employer-based health insurance, growth in premiums and cost-sharing has largely erased wage gains over the past decade.[14]

Rising health care spending has a profound effect on public budgets as well. Federal spending on Medicare and Medicaid increased from 1 percent to 5 percent of GDP between 1970 and 2009, and is projected to reach 12 percent by 2050.[15] The Congressional Budget Office has identified it as the primary cause of projected federal budget deficits.[16] Medicaid spending also impacts state budgets, increasing faster than and potentially crowding out other socially desirable budget items, such as education and infrastructure.

While all the countries in this study struggle in one way or another with health care costs, financing the U.S. health system requires a unique commitment of resources. Were the U.S. to spend the same share of GDP on health care as the Netherlands—the country spending the next-largest share of GDP—savings for the nation as a whole would have been $750 billion in 2009 alone. Were the U.S. to spend the same share of GDP as Japan, savings would have totaled $1.25 trillion—an amount larger than the U.S. defense budget.

As the lowest-spending nation in this study, Japan offers an interesting contrast to the U.S. In some ways, the two countries' health systems share similar features. Japan operates a fee-for-service system, characterized by unrestricted access to specialists and hospitals.[17] Advanced medical technology also appears to be widely available, with Japan having the most CT scanners and MRI machines among the countries in this study. Yet health spending in Japan as a share of GDP has increased by only 2 percentage points in the past three decades, compared with an increase of more than 8 percentage points in the U.S. over the same period.

Notably, the Japanese do not restrain spending by restricting access; rather, they do so by aggressively regulating health care prices.[18] Every two years, a panel of experts uses volume projections to revise the national fee schedule, which determines the maximum prices for nearly all health services, to keep total health spending growth within a target set by the central government. Providers' profitability is also monitored, and when certain categories of providers (e.g., acute care hospitals or ambulatory specialists) demonstrate significantly greater profitability than the average, prices for their services are reduced. Despite such overt price controls, the results are hard to dispute—the Japanese enjoy the longest life expectancy in the world.

In the U.S., private payers individually negotiate prices with health care providers, in a process characterized by administrative complexity and a lack of transparency. For example, hospitals often charge different payers widely varying prices that are, on average, far below those listed on hospitals' official price lists.[19] The economist Uwe Reinhardt and others have argued that such price discrimination is not in the public interest, and that an all-payer system—as in Japan, Germany, and several other nations—would be more equitable, efficient, and potentially effective at reining in spending growth.[20] Such a system is not completely foreign to the U.S. The state of Maryland has operated an all-payer system for hospitals since 1977, and has seen costs per admission rise slower than the national average.[21]

Inevitably, efforts to control health care spending involve trade-offs, and many such efforts—whether restricting access or regulating prices—come with a cost. Lower drug prices may lead to less research and development and, consequently, fewer pharmaceutical breakthroughs. Lower provider incomes could reduce the quality of applicants choosing a career in medicine. These drawbacks need to be measured against the opportunity costs of health care crowding out other forms of public investment, and of vulnerable household budgets being exposed to the most expensive health care system in the world.

Methods

The Organization for Economic Cooperation and Development (OECD) annually tracks and reports on more than 1,200 health system measures across 34 industrialized countries, ranging from population health status and non-medical determinants of health to health care resources and utilization. This analysis examined 2011 OECD health data for 13 countries: Australia, Canada, Denmark, France, Germany, Japan, Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States. This brief presents data for the year 2009 or, where not available, 2008 or 2007. The median for all OECD countries is also included in Exhibits 2, 3, 4, 5, 8, 10 and 11; for Exhibits 6 and 9, the median is included for only the countries shown, because of incompleteness of data. All currency amounts are listed in U.S. dollars (USD) and adjusted for national differences in cost of living.

Data are also included from an analysis by Gerard Anderson of IMS Health data on pharmaceutical prices; an analysis by Miriam Laugesen and Sherry Glied on physician fees and income, originally published in *Health Affairs*; and the International Federation of Health Plans on the cost of diagnostic tests.

Notes

S. Thomson, R. Osborn, D. A. Squires, and S. J. Reed, International Profiles of Health Care Systems, (New York: The Commonwealth Fund, Nov.).

Organization for Economic Cooperation and Development, OECD Health Data (Paris: OECD, Nov.).

D. A. Squires, The U.S. Health System in Perspective: A Comparison of Twelve Industrialized Nations (New York: The Commonwealth Fund, July); G. F. Anderson and D. A. Squires, Measuring the U.S. Health Care System: A Cross-National Comparison (New York: The Commonwealth Fund, June); G. F. Anderson and B. K. Frogner, Health Spending in OECD Countries: Obtaining Value per Dollar, Health Affairs, Nov./Dec. ( ): ; G. F. Anderson, B. K. Frogner, and U. E. Reinhardt, Health Spending in OECD Countries in : An Update, Health Affairs, Sept./Oct. ( ): ; G. F. Anderson, P. S. Hussey, B. K. Frogner et al., Health Spending in the United States and the Rest of the Industrialized World, Health Affairs, July/Aug. ( ): ; U. E. Reinhardt, P. S. Hussey, and G. F. Anderson, U.S. Health Care Spending in an International Context, Health Affairs, May/June ( ): ; G. F. Anderson, U. E. Reinhardt, P. S. Hussey et al., It s the Prices, Stupid: Why the United States Is So Different from Other Countries, Health Affairs, May/June ( ): ; U. E. Reinhardt, P. S. Hussey, and G. F. Anderson, Cross-National Comparisons of Health Systems Using OECD Data, , Health Affairs, May/June ( ): ; G. F. Anderson and P. S. Hussey, Comparing Health System Performance in OECD Countries, Health Affairs, May/June ( ): ; G. F. Anderson, J. Hurst, P. S. Hussey et al., Health Spending and Outcomes: Trends in OECD Countries, , Health Affairs, May/June ( ): ; and G. F. Anderson and J. P. Poullier, Health Spending, Access, and Outcomes: Trends in Industrialized Countries, Health Affairs, May/June ( ): .

All dollar amounts are adjusted for differences in the cost of living between countries.

Regression includes all OECD countries, except Luxembourg. For health spending per capita: coefficient . and intercept . For health spending as a percentage of GDP: coefficient . and intercept . . Similar analysis in Anderson and Frogner, Health Spending in OECD Countries, .

E. A. Finkelstein, J. G. Trogdon, J. W. Cohen et al., Annual Medical Spending Attributable to Obesity: Payer- and Service-Specific Estimates, Health Affairs, Sept./Oct. ( ):w w .

G. F. Anderson and P. Markovich, Multinational Comparisons of Health Systems Data, (New York: The Commonwealth Fund, July).

M. J. Laugesen and S. A. Glied, Higher Fees Paid to U.S. Physicians Drive Higher Spending for Physician Services Compared to Other Countries, Health Affairs, Sept. ( ): .

International Federation of Health Plans, Comparative Price Report: Medical and Hospital Fees by Country (London: IFHP,), available at http://www.ifhp.com/documents/ iFHPPriceReportGraphs_version .pdf.

Centers for Disease Control and Prevention, Chronic Diseases and Health Promotion.

This measure does not account for deaths that occur outside the hospital to which the patient was admitted, meaning rates may be influenced by referral patterns and hospital lengths of stay.

Underinsured adults are those between ages and with: family out-of-pocket medical care expenses (not including premiums) that are percent or more of income; among low-income adults (i.e., incomes below percent of the federal poverty level), medical expenses that are percent or more of income; or per-person deductibles that are percent or more of income. See C. Schoen, M. M. Doty, R. H. Robertson, and S. R. Collins, Affordable Care Act Reforms Could Reduce the Number of Underinsured U.S. Adults by Percent, Health Affairs, Sept. ( ): .

D. U. Himmelstein, D. Thorne, E. Warren et al., Medical Bankruptcy in the United States, : Results of a National Study, American Journal of Medicine, Aug. ( ): .

D. I. Auerbach and A. L. Kellermann, A Decade of Health Care Cost Growth Has Wiped Out Real Income Gains for an Average U.S. Family, Health Affairs, Sept. ( ): .

M. E. Chernew, K. Baicker, and J. Hsu, The Specter of Financial Armageddon Health Care and Federal Debt in the United States, New England Journal of Medicine, April , ( ): .

Letter from Douglas W. Elmendorf, Director, Congressional Budget Office to Kent Conrad, Chairman, Senate Committee on the Budget, June , , http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/ xx/doc / - -healthreformandfederalbudget.pdf.

D. A. Squires, The Japanese Health Care System, in: Thomson, Osborn, Squires, and Reed, International Profiles of Health Care Systems, .

N. Ikegami and J. C. Campbell, Japans Health Care System: Containing Costs and Attempting Reform, Health Affairs, May/June ( ): .

U. E. Reinhardt, The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy, Health Affairs, Jan./Feb. ( ): .

U. E. Reinhardt, The Many Different Prices Paid to Providers and the Flawed Theory of Cost Shifting: Is It Time for a More Rational All-Payer System? Health Affairs, Nov. ( ): .

R. Murray, Setting Hospital Rates to Control Costs and Boost Quality: The Maryland Experience, Health Affairs, Sept./Oct. ( ): .

About the Author

David A. Squires, M.A., is senior research associate for the International Program in Health Policy and Innovation at The Commonwealth Fund. He is responsible for research support for the Fund's annual international health policy surveys; researching and tracking health care policy developments in industrialized countries; preparing presentations; monitoring the research projects of the current class of Harkness Fellows; and tracking the impact of the fellows' projects and publications on U.S. and home country policy. Squires joined the Fund in September 2008, having worked for Abt Associates, Inc., as associate analyst in domestic health for the previous two years. Squires graduated magna cum laude with a B.A. in English and minors in economics and philosophy from Bates College. He holds a master's degree in bioethics from New York University.

Acknowledgments

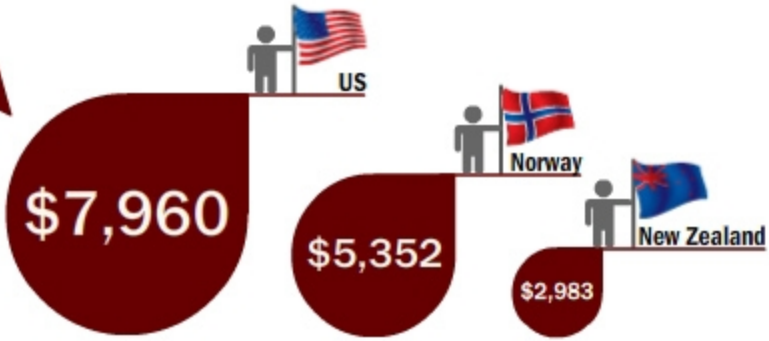
The author would like to thank Robin Osborn, Cathy Schoen, and Tony Shih for their contributions to this brief.

Editorial support was provided by Deborah Lorber.

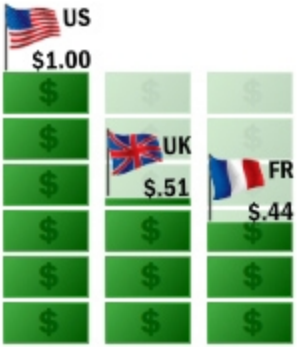
U.S. Spends Much More on Health Care Than 12 Industrialized Nations, but Quality Varies

THE COMMONWEALTH FUND

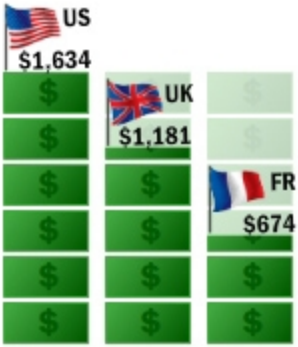
The U.S. Spends the Most per Person on Health Care Annually



Americans Pay More for the Same Health Care Goods and Services



Most Commonly Prescribed Drugs



Physician Fee for Hip Replacement (public payer)

Uneven Quality Despite High Spending

In-Hospital Deaths After a Heart Attack Admission (per 100 patients)

Explaining High Health Care Spending in the United States: An International Comparison of Supply, Utilization, Prices, and Quality, The Commonwealth Fund, May 2012. http://www.commonwealthfund.org/Publications/Issue-Briefs/2012/May/High-Health-Care-Spending.aspx

CALIFORNIA HEALTHCARE FOUNDATION
SUPPORTING IDEAS & INNOVATIONS TO IMPROVE HEALTH CARE FOR ALL CALIFORNIANS

Health-e-App Public Access: Modernizing the Path to Children's Health Coverage in California

Mathematica Policy Research

Since December 2010, Californians have been able to use a self-service, online application for Healthy Families and Medi-Cal for Families. Health-e-App Public Access offers faster, more convenient access to public insurance.

May 2013

Since December 2010, Californians have been able to use a self-service, online application for Healthy Families and for the Medi-Cal Program for Children and Pregnant Women. This enrollment option, called Health-e-App Public Access (HeA PA), offers faster, more convenient access to public insurance for children. A series of reports from Mathematica Policy Research, supported by CHCF and the David and Lucile Packard Foundation, examines the impact of this new enrollment route in 2011, its first full year of operation.

The third report (May 2013) describes and evaluates a seven-month outreach campaign, conducted primarily online. It finds that:

- The online outreach campaign (July 2011–July 2012) led to 138,000 visits to the HeA PA website, representing about 64% of all visits during those months. This was approximately double the average monthly number of unique visitors to the website in the previous six months.
- The outreach campaign did not lead to more applications from ineligible families.
- The campaign appears to have been successful in reaching target Latino audiences. In areas where the outreach campaign specifically targeted Spanish-speaking Latinos, average monthly HeA PA applications showed a particular increase.

The second report (February 2013) describes HeA PA applicants and their experiences with the self-service tool. It draws on data, including responses to optional survey questions received from nearly 15,000 applicants.

- In 2011, applicants who used HeA PA were somewhat younger and had slightly higher incomes than applicants who used paper applications or applied online with help.
- Almost all HeA PA applicants used the tool in English. HeA PA applicants were far more likely than people who used paper applications or had assistance to say they preferred handling all application-related communications in English.
- Most HeA PA applicants said they use the Internet regularly. Two-thirds submitted applications from their own computer, and nearly all used a high-speed connection.
- Slightly more than half of applicants said they used an HeA PA help feature. More applicants used an online help feature than used live help over the phone.

- Nearly all HeA PA users found the application easy to use and said they would recommend it to family and friends.

Findings from the first report (March 2012) include:

- In the first year, HeA PA usage was steady at approximately 4,000 applications per month, despite no marketing campaign upon launch.
- Use of HeA PA was associated with a 14% increase in total applications submitted to the state processing center from 2010 to 2011. The growth in total 2011 applications appears entirely attributable to the availability of the tool.
- Sixty-four percent of HeA PA applications were submitted with all required documentation. This rate is lower than that for assisted online applications (79%) but higher than that for paper (61%).

The reports are available on the Mathematica website through the External Link below.

RELATED CHCF PAGES

Health-e-App

One-e-App: One-Stop Access to Health and Social Service Programs

EXTERNAL LINKS

Mathematica Policy Research — Health-e-App Public Access: A New Online Path to Children's Health Care Coverage in California

Lucile Packard Foundation for Children's Health

Issue Brief

May 2013

Private Coverage Under California's Affordable Care Act: Benefit and Cost-Sharing Requirements Affecting Children and Adolescents with Special Health Care Needs

by Peggy McManus and Harriette Fox, The National Alliance to Advance Adolescent Health

Executive Summary

Plans providing insurance in the California Health Benefit Exchange and in individual and small group markets will use Kaiser Permanente's HMO Plan for Small Businesses as their essential health benefits benchmark plan. This benchmark plan offers a broad set of benefits that should meet the needs of most children and adolescents, including those with special health care needs. The breadth of preventive care coverage, as required by the Affordable Care Act (ACA) and expanded under the Kaiser plan, is more generous than what is currently available in most plans sold to individuals or small businesses. In addition, the continuum of mental health and substance abuse treatment and the range of rehabilitive and habilitive services provide an expansive set of essential health benefits.

This benchmark plan offers a broad set of benefits that should meet the needs of most children and adolescents, including those with special health care needs.

Visit limits are seldom applied to essential health benefits. However, Kaiser's benchmark plan relies on authorization criteria to determine the amount, duration, and scope of specific services. Like Kaiser, qualified health plans sold through the health benefit exchange will adopt prior authorization and medical necessity criteria which, in effect, function as benefit limits. Given the breadth of covered services in the benchmark plan, utilization management strategies are likely to be stringent to constrain health benefit costs.

Importantly, California has elected to adopt Kaiser's benefits without substitution, except for prescription drugs. This state policy will ensure a level of uniformity in coverage among health plans sold inside and outside of California's Health Benefit Exchange beginning in 2014.

Despite the broad range of covered benefits, there are still some services important for the care of children and adolescents with special health care needs that are not covered under the benchmark plan. These include family therapy, inpatient chemical dependency treatment beyond detoxification, long-term intensive outpatient care and long-term residential treatment for mental health disorders and chemical dependency. Long-term home health care and hearing aids and cochlear implants also are expressly omitted.

The California Health Benefit Exchange has developed standard plan designs that all participating carriers will offer. Benefits are the same in all of the standard plan designs. However, cost-sharing obligations differ significantly by the type of plan selected – platinum, gold, silver, bronze, and catastrophic – and also by household income. With respect to deductible requirements, platinum and gold plans have none, but families in the non-subsidized silver plan will face a $4,000 deductible for certain medical services and a $500 deductible for brand-name drugs. Much higher deductibles will apply in the bronze and catastrophic plans – $10,000 and $12,800, respectively. Co-payment and co-insurance rates also will differ by plan type, with platinum plans offering the lowest rates and bronze plans the highest. The out-of-pocket maximum limit for families will be $8,000 in the platinum plan and $12,800 in each of the other types of plans. Still another affordability concern is the separate cost-sharing requirements and out-of-pocket maximum for pediatric dental services.

Cost-sharing obligations differ significantly by the type of plan selected – platinum, gold, silver, bronze, and catastrophic – and also by household income.

For families and individuals with incomes between 100% and 400% of the federal poverty level (FPL), premium credits and cost-sharing subsidies represent a significant protection against high medical costs. Despite these important protections afforded by the ACA, out-of-pocket costs for those with incomes above 200% FPL are still significant in the subsidized silver plan. Families with incomes between 200% and 250% FPL will have to meet a $3,000 deductible, which applies to hospital and emergency room services, and a $500 deductible for brand-name drugs. In addition, they will have significant co-payment and co-insurance requirements for non-preventive services, including $40 per primary care visit and 20% for inpatient hospital care.

As uninsured families with children who have special health care needs consider their private coverage options under California's Affordable Care Act, they should first determine if their child is exempt from enrollment in private benchmark coverage and is eligible instead for Medi-Cal benefits, which for children include all of the essential health benefits – to the extent that they are deemed medically necessary – without premium or cost-sharing requirements. Categories of income-eligible exempt individuals include, but are not limited to, those who qualify under the state's definition of medically frail. This includes those with serious emotional disturbances, serious and complex medical conditions, and individuals with physical or mental disabilities that significantly impair their ability to perform activities of daily living. It also includes pregnant women and children in foster care or receiving foster care or adoption assistance.[1, 2]

Important Questions Remain

With so many new policies being adopted under California's Affordable Care Act, it will be important for policymakers, researchers, and advocacy organizations to monitor several issues important to children and adolescents with special health care needs. What is the state's definition of medically frail individuals and how are income-eligible families being informed of this during eligibility determination? Are families who select lower

cost plans (i.e., silver, bronze, and catastrophic) receiving sufficient information about their out-of-pocket cost liabilities if they are not eligible for subsidies? To what extent are cost-sharing requirements in these plans exposing families and their providers to medical debt and serving as a barrier to receipt of needed medical care? Are state-mandated benefits for children being covered as required? Are pediatric medical and mental health specialists and hospitals participating as in-network providers in qualified health plans? If not, will families whose children and adolescents have chronic conditions need to go out of network to receive care and be obligated to meet higher co-payment or co-insurance requirements? Finally, how will coordination of benefits and care work for families whose children are eligible for California Children's Services or for California's public mental health services?

California officials made a very good choice in selecting the Kaiser small group plan as the state's essential health benefits benchmark plan because of its expansive benefit coverage relative to most small group plans. As directed by HHS, the state is offering a variety of products with the same set of benefits but very different cost-sharing requirements. To the extent that families can purchase platinum or gold plans, they will have much greater protection from high out-of-pocket costs than those who purchase silver, bronze, or catastrophic plans.

Introduction

This policy brief examines the extent to which California's essential health benefits benchmark plan – Kaiser's Small Group HMO Plan – meets the needs of children and adolescents, including those with special health care needs. It also examines the cost-sharing requirements that will be used by health insurance plans sold in California's Health Benefit Exchange, including the subsidized silver plan, and discusses implications for families and policymakers.

A total of 70 services were analyzed under the 10 essential health benefit (EHB) categories required by the Department of Health and Human Services (HHS) to implement the Affordable Care Act (ACA) (Table 1). These services were selected based on recommendations from the American Academy of Pediatrics and the Children's Dental Project and from past benefit research conducted by the authors.[3]

To the extent that families can purchase platinum or gold plans, they will have much greater protection from high out-of-pocket costs than those who purchase silver, bronze, or catastrophic plans.

Information for this brief was obtained from several sources. Benefit information was based on Kaiser's "Evidence of Coverage" document[4] and an interview with a senior Kaiser Permanente official. Cost-sharing information was based on the "Covered California" Standard Benefit Plan Designs Summary of Benefits and Coverage.[5] Additional documents were analyzed, including Senate Bill 951[6] and Assembly Bill 1453,[7] California's Health Benefit Exchange's Qualified Health Plan Solicitation to Health Issuers,[8, 9] California's mandated benefits, and reports on health reform implementation in California.[10, 11]

There are a few important limitations. The benefit and cost-sharing policies are for preferred or in-network providers only. The cost-sharing information reported on is for co-

pay plans only. The prescription drug benchmark formulary was not analyzed because qualified plans are able to submit substitutions to their benchmark formulary. Information on subsidized dental coverage was not available when this report was prepared. Final premium information also was not available.

The policy brief is organized into three sections: 1) background on California's essential health benefits benchmark plan and cost-sharing requirements; 2) the strengths and limits of benchmark benefits and cost-sharing requirements within all five levels of coverage [platinum, gold, silver (including subsidized coverage for those between 100% and 250% FPL), bronze, and catastrophic] and potential issues of concern; and 3) a comparison of private benchmark coverage and Medi-Cal benefits, including its Early and Periodic Screening, Diagnosis, and Treatment Program (called Child Health Development Program or CHDP in California). Detailed tables on benefits, cost sharing, and state mandates are included.

Background on California's Selection of a Benchmark Plan and Definition of Essential Health Benefits

California's Senate Bill 951 and Assembly Bill 1453, signed into law by Governor Brown on September 30, 2012, designated Kaiser's Small Group HMO 30 Plan as its essential health benefits benchmark plan required under the ACA.

Starting January 1, 2014, all individual health insurance policies and small group plans inside and outside of California's Health Benefit Exchange must offer the health benefits covered by Kaiser's benchmark plan. California prohibits insurers from making benefit substitutions, except for prescription drugs,[12] and also prohibits insurers from imposing treatment limits that exceed those in Kaiser's benchmark plan.

Plans exempt from these federal and state benefit requirements are grandfathered plans (health plans in existence on March 23, 2010, when the ACA became law), large employer plans (>50 employees), and self-insured plans of any size. California's benchmark plan will apply for 2014 and 2015. Starting in 2016, HHS will direct states about future essential health benefits options.

The EHBs specified under the ACA include 1) ambulatory patient services, 2) emergency services, 3) hospitalization, 4) maternity and newborn care, 5) mental health and substance abuse services, including behavioral health treatment, 6) prescription drugs, 7) rehabilitation and habilitative services, 8) laboratory services, 9) preventive and wellness services and chronic disease management, and 10) pediatric services, including oral and vision care.

HHS provided states with minimal guidance on the amount, duration, and scope of services to be covered under each of these 10 required benefits. The exception has been with respect to mental health and substance abuse services,[13] prescription drugs,[14] habilitative services,[15] preventive care,[16] and pediatric oral and vision services,[17] as described in the footnotes.

In addition, Secretary Sebelius required that EHBs should be equal to the scope of benefits provided in a typical employer plan, which has subsequently been referred to as a small group

plan. EHBs, according to the HHS Secretary, also should reflect a balance between the 10 benefit categories, take into account the needs of diverse segments of the population, including children, and ensure discrimination protections.[18]

In addition to HHS' requirements, California's Senate Bill 951 and Assembly Bill 1453 clarified the state's EHB requirements for habilitative and pediatric oral and vision care as follows.

- *Habilitative* benchmark benefits are covered under the same terms and conditions applied to rehabilitative services. They are defined as "medically necessary health care services and health care devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual's environment. Examples of health care services that are not habilitative services include, but are not limited to, respite care, day care, recreational care, residential treatment, social services, custodial care, or education services of any kind, including, but not limited to, vocational training."
- *Pediatric oral care* benchmark benefits are covered as the benefits under California's Healthy Families Program in 2011-12, including medically necessary orthodontic care.
- *Pediatric vision care* benchmark benefits are covered as the benefits under the BlueCross BlueShield Fed Blue Vision Federal Employees Vision Program (FedVIP).

California's qualified health plans will include several mandated benefits affecting children and adolescents that were enacted prior to 2011. These mandates, described in Table 4, include medically necessary benefits for pediatric asthma and diabetes, contraceptives, HIV and HPV testing and treatment, reconstructive surgery for congenital defects or developmental abnormalities, phenylketonuria testing and treatment, mental health parity, and behavioral health treatment for pervasive developmental disorder and autism.

Despite the fact that qualified plans in California's exchange must cover essentially the same set of benefits specified in the Kaiser benchmark plan, qualified health plans can offer a range of insurance products at different actuarial or "metal" levels, and the amount of cost sharing required will differ in these plans. Platinum plans will require the least cost sharing, and catastrophic plans, as their name implies, will require the most. Importantly, individuals and families with household incomes between 100% and 400% of the federal poverty level (FPL), ($19,530 up to $78,120 for a family of three) will be eligible for assistance with their monthly premiums in the form of a tax credit. For individuals and families with incomes between 100% and 250% of the FPL ($19,530 up to $48,825 for a family of three), additional cost-sharing assistance will be available in the form of lower deductibles, co-payments, and co-insurance.

Habilitative benchmark benefits are covered under the same terms and conditions applied to rehabilitative services.

The tax credit assistance is available only to families purchasing insurance through the exchange and is based on the cost of the silver plan. Should a family elect to purchase either richer coverage (platinum or gold) or leaner coverage (bronze or catastrophic), the amount of the tax credit can be applied to the premium costs of those plans.

Although final premium prices were not available when this report was prepared, the upper limit of cost-sharing amounts has been established by the state for qualified health plans that will be sold to individuals, families, and small businesses in 2014. The actuarial value for each plan, as shown in Table 2, ranges from a high of 88% in the platinum plan (the percentage of health costs that a health plan will pay for an average person) to a low of 60.4% in the catastrophic plan. That means, on average, that in a platinum plan, enrollees will be paying about 12% of the costs, and in a catastrophic plan, about 40%.

The use and amount of deductibles vary by actuarial level or plan type. (In this report, we report on family, not individual, deductibles.) Platinum and gold plans have no overall deductible or medical or dental deductible. The silver plan, however, has a $4,000 deductible that applies to certain medical services and a $500 deductible for brand-name drugs. The bronze plan has an overall deductible of $10,000 that applies to all covered services, except for preventive care, prenatal care, and the first three ambulatory care visits. The catastrophic plan has an overall deductible of $12,800 that applies to all services, except for preventive care services and the first three non-preventive care visits. To protect against high out-of-pocket costs, all of the plans set a maximum limit after which the plan will fully pay for covered services at no additional cost to the member. In the platinum plan the out-of-pocket limit on expenses for a family is $8,000, and in all of the other plans, the out-of-pocket maximum is $12,800.

In a platinum plan, enrollees will be paying about 12% of the costs, and in a catastrophic plan, about 40%.

Strengths and Limits of Benchmark Plan Benefit and Cost-Sharing Requirements in Platinum, Gold, Silver, Bronze, and Catastrophic Plans

1. Ambulatory Services

Primary care visits, specialist visits, other practitioner visits, and urgent care are covered in the Kaiser benchmark plan without visit limits, as shown in Table 1. The cost-sharing requirements for these services differ by plan type, as shown in Table 2.

In general, co-payment rates for primary care visits and other practitioner visits are set at the same amount, and specialist visit co-payment rates are up to two times higher than the primary care co-payment rates. In both the bronze and catastrophic plans, the deductible applies after the first three non-preventive office or urgent care visits (including mental health and substance abuse visits).

Potential Issues of Concern:

- Although ambulatory benefits are available without limits, qualified plans can impose authorization requirements for specialists and other practitioners (which include physical, occupational, and speech

therapists) that may need to be examined. (Note: Kaiser's referral and authorization policies do not have to be adopted by qualified health plans.) For example, authorization requirements may limit access to therapy services by requiring significant improvement within a short period of time or by excluding conditions not caused by an illness or injury.

- The requirement for meeting the deductible in bronze and catastrophic plans may be a significant deterrent to families seeking ambulatory services.

2. Preventive and Wellness Services and Chronic Disease Management

The Kaiser benchmark plan covers all of the preventive services listed in Table 1, including preventive care, screening, immunizations, health education counseling and programs, developmental screening, alcohol and other substance abuse screening, family planning counseling, and STD preventive counseling. No cost sharing is allowed for these services, according to the ACA.

Potential Issues of Concern:

- Qualified health plans may not provide new enrollees with an explanation of the full scope of preventive services required by the ACA and covered in the Kaiser benchmark plan. It is not enough to list preventive benefits as "well child preventive exams" or "routine physical maintenance exams."

3. Emergency Services

Emergency room services and medical transportation are covered in the Kaiser benchmark plan without limits, except for the requirement that an individual using the service must have an "emergency medical condition."[19] Importantly, cost sharing for emergency room services in all of the plans will be waived if the patient is admitted. Otherwise, families will need to meet sizeable deductibles in the silver, bronze, and catastrophic plans.

Co-payments are substantially higher for emergency room services than for ambulatory services, ranging from $150 in the platinum plan to $300 in the bronze plan.

Potential Issues of Concern:

- The deductible requirements in silver, bronze, and catastrophic plans may present a significant financial burden for families whose children require emergency room care and are not hospitalized.

4. Hospitalization

Inpatient and outpatient hospital services are covered without limits in Kaiser's benchmark plan. The cost-sharing policies for these hospital services vary sharply by plan type. The most generous plan – the platinum plan – requires a $250 daily co-pay for up to five inpatient hospital days or a maximum of $1,250. Outpatient surgery facility and physician fees in the platinum plan have a $250 co-payment, as well. In the gold plan, co-payment rates for inpatient hospital care jump to $600 per day for up to five days or to a maximum of $3,000, and for outpatient hospital surgical care the cost-sharing fee is $600. In the silver plan, a co-insurance rate of 20% is used for inpatient hospital care, and the same co-insurance rate applies to outpatient hospital surgery services. The cost-sharing obligations for both inpatient hospital care and outpatient hospital surgery services continue to increase in the bronze plan to 30%. In both the silver and bronze plans,

deductibles apply to inpatient care, and to outpatient hospital surgical care in the silver plan. Finally, in the catastrophic plan, there is no cost sharing after the high overall deductible is met.

Potential Issues of Concern:

- Parents in all plans and especially in silver, bronze, and catastrophic plans may not be fully aware of their significant out-of-pocket liabilities for hospital care.
- Hospitals may incur bad debt/uncompensated care as a result of families' inability to meet high deductible expenses and other co-payment or co-insurance requirements.

5. Maternity and Newborn Care

The Kaiser benchmark plan covers prenatal and preconception services and inpatient delivery services without visit restrictions. Consistent with ACA requirements, no cost sharing is allowed for prenatal and preconception services. Hospital cost-sharing policies apply to inpatient delivery and physician and surgeon services: in the platinum plan, $250/day up to 5 days; in the gold plan, $600/day up to 5 days; in the silver plan, 20% and the deductible applies; and in the catastrophic plan, the $12,800 deductible applies.

Potential Issues of Concern:

- Parents may not be fully aware of the hospital delivery cost-sharing obligations, including deductible requirements and co-payments or co-insurance, particularly since they have coverage for prenatal care without cost sharing.

6. Laboratory Services

There are no restrictions on laboratory services in the Kaiser benchmark plan. Cost sharing varies by type of service, with lab tests having the lowest out-of-pocket fees and imaging services having the highest in platinum, gold, and silver plans. None of these three types of plans applies the deductible to lab services. In contrast, the bronze plan requires a 30% co-insurance rate for each type of lab service (lab tests, x-rays, and imaging), and the $10,000 deductible must be met. In the catastrophic plan there is no cost sharing after the high overall deductible ($12,800) is met.

Potential Issues of Concern:

- Qualified health plans may not make clear in their plan brochures what lab tests are part of preventive care services and thus without cost sharing.
- Since lab services are so commonly used by children and especially by adolescents, the deductible requirements in the bronze and catastrophic service may represent a significant financial burden of which the prescribing provider is likely to be unaware, and may in some cases impede individuals from obtaining needed lab services.

7. Prescription Drugs

Kaiser's benchmark plan covers prescription drugs – generic, brand-name, and specialty drugs – according to its formulary guidelines. As discussed earlier, qualified plans are allowed to use their own prescription drug formulary as long as coverage for prescription drugs complies with California's mandated benefits. In all plans, the co-payment/co-insurance difference between generic and specialty drugs is significant, and deductible requirements apply

in silver, gold, and bronze plans. The most generous plan, the platinum plan, has a drug co-pay that increases from $5 per generic drug to 10% for specialty drugs. The gold plan drug cost-sharing amount ranges from $20 to 20%. A similar cost-sharing requirement applies in the silver plan after a $500 family drug deductible is met. The bronze plan drug cost-sharing amount increases from $25 to 30%, and the overall deductible applies. Catastrophic plan enrollees must meet their $12,800 deductible before the plan reimburses for any drugs.

Potential Issues of Concern:

- Further examination may be needed of qualified health plan formularies as they pertain to children and adolescents. If certain drugs are not on plan formularies, families will be responsible for full payment.
- Qualified health plans may not make clear in their plan brochures that contraceptives are covered without cost sharing.
- The high deductible requirements in bronze and catastrophic plans may lead families and older adolescents and young adults to forgo obtaining prescription medications, even generic drugs.

8. Mental Health and Substance Abuse Services, including Behavioral Health Treatment

Kaiser's benchmark plan offers a continuum of mental health and chemical dependency services, including psychological testing, individual and group outpatient therapy, pharmacotherapy, inpatient psychiatric treatment, inpatient detoxification services, intensive outpatient care, and residential programs, for children and adults with disorders, including serious emotional disorders and serious mental illness. In addition, as a result of California's mandated benefits (Table 4), applied behavior analysis and evidence-based behavior intervention programs are covered for individuals with pervasive developmental disorder and autism. The Kaiser benchmark plan, however, excludes family therapy and inpatient hospital treatment for chemical dependency beyond detoxification. Coverage of intensive outpatient care and residential treatment is only covered for short-term treatment, which will be defined by insurers' authorization criteria. The same cost-sharing policies described above under hospitalization apply to mental health and substance user disorder services.

Potential Issues of Concern:

- Although mental health and substance use disorder benefits are covered in the benchmark plan without limits, qualified plans' authorization requirements may need to be carefully reviewed to ensure that certain conditions are not excluded – for example, children whose primary diagnosis is a chronic medical condition or a behavior disorder or an eating disorder.
- Families may not be aware of the availability of the state's Department of Mental Health services for those children and adolescents who meet their eligibility criteria and require longer term intensive outpatient care and residential treatment.

9. Rehabilitative and Habilitative Services and Devices

The Kaiser benchmark plan covers a broad set of rehabilitative and habilitative services and

devices, including physical, occupational, and speech therapy; home health care; skilled nursing facility care; durable medical equipment; medical supplies; and hospice care. Audiology tests, hearing aids, and cochlear implants, however, are not covered. Home health care is covered on a part-time or intermittent basis for up to 100 visits per year, and skilled nursing facility care is capped at 100 days per benefit period (see Table 2 for explanation). Insurers will apply their own authorization criteria for enrollees to access rehabilitative and habilitative services (addressing, for example, authorized access based on functional status, activity of daily living goals, or level of improvement). In each of the platinum, gold, and silver plans, the cost-sharing amount for rehabilitative, habilitative, and home health services is the same as for ambulatory services, and no deductible applies. In contrast, deductibles apply for rehabilitative and habilitative services and devices in bronze and catastrophic plans. Co-insurance rates are applied to DME and medical supplies, ranging from 10% to 30%, depending on the plan type. Again, in the bronze and catastrophic plans, the deductible applies. Cost-sharing policies for skilled nursing facility services are the same as for hospital care, and no cost sharing is allowed for hospice care.

Potential Issues of Concern:

- Qualified plans' authorization requirements for rehabilitative and habilitative services may require careful review to ensure that they address children's needs.
- Families may not be aware of the availability of the state's California's Children's Services (CCS) Program for those children and adolescents who meet their eligibility requirements and require longer term rehabilitative or habilitative services and certain DME, such as hearing aids or cochlear implants.

10. Pediatric Services, Including Dental and Vision Care

Kaiser's benchmark plan does not cover dental and vision care, so the state, under the ACA, was required to obtain supplemental coverage for these pediatric benefits. The state designated Healthy Families Program benefits as their pediatric dental benchmark. This plan (which is in the process of transferring its enrollees to Medi-Cal) offers a broad set of dental services, including preventive, diagnostic, and restorative care, including fillings, oral surgery, root canals, and crowns and bridges. Orthodontia services for medically handicapping malocclusion are available only for children under 18 through the CCS program.

With respect to vision care, the state designated BlueCross BlueShield Federal Employee Program "Blue Vision" as its pediatric vision benchmark. This plan covers diagnostic eye exams, one pair of lenses per year, and contact lenses in lieu of eyeglasses. Cost sharing for pediatric dental and vision care is based on four different types of benefit plan designs: a high and low option PPO and a high and low option HMO. Cost sharing for these plans is separate from the cost sharing applied to other EHBs. The high option HMO and PPO dental plans have about the same actuarial value – 86%/87%, and the low option HMO and PPO dental plans have a 72% actuarial value. The HMO plans have no deductible, and the PPO plans have a relatively low deductible ($50/$60), which is not applied to preventive and diagnostic

services. All of the plans have the same out-of-pocket limit on expenses – $1,000 – and none of the plans has any co-payment for preventive exams, prophylaxis, fluoride treatment, radiographs, and sealants.

Potential Issues of Concern:

- Families may not be aware of the requirement that different and additional cost sharing applies for dental and vision care, including deductible requirements and out-of-pocket protections.
- Families may not be aware of CCS eligibility criteria for orthodontia and the state mandated coverage of anesthesia for certain children requiring dental surgery or procedures (Table 4).

Comparison of Private Benchmark Coverage and Medi-Cal and EPSDT Coverage

Although benefit coverage for children and adolescents under the Kaiser essential health benefits benchmark plan is quite generous, the coverage available under Medi-Cal and its Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program (referred to as the Child Health and Disability Prevention Program or CHDP in California) is more expansive and carries no cost-sharing obligations, as shown in Table 5.

Under the EPSDT benefit, eligible children under age 21 have coverage for medically necessary services allowed under the federal Medicaid program to correct or ameliorate any physical or mental illness or other condition discovered as part of preventive care. Services such as family therapy, private duty nursing, hearing aids, cochlear implants, extended home health care, and longer term mental health and substance abuse treatment are covered if they are determined to be medically necessary and authorized by the state.

However, Medi-Cal requires that these services be offered only by certain qualified providers. For example, family therapy and special day programs are available from the county mental health department, and additional therapy services are available from designated California Children's Services providers.

Understanding the benefit and cost-sharing distinctions between private benchmark coverage and Medi-Cal and EPSDT is important for families whose children qualify as exempt from mandatory enrollment in benchmark coverage. As discussed earlier, these include individuals who are medically frail, as defined by the state, including those with serious emotional disturbances, serious and complex medical conditions, and those with physical or mental disabilities.

- *The National Alliance to Advance Adolescent Health, a non-profit organization, provides education, research, policy analysis, and technical assistance to achieve improvements in the way that adolescent health care is structured and delivered in the United States. For more information, visit www.thenationalalliance.org.*

Footnotes

[1] Musumeci M. *Medicaid Eligibility and Enrollment for People with Disabilities Under the Affordable Care Act.* Washington, DC: Kaiser Commission on Medicaid and the Uninsured, December 2012.

[2] Youdelman M. *Ensuring Accessibility for Individuals with Disabilities in the ACA's Marketplaces.* Washington, DC: National Health Law Program, May 2013.

[3] McManus P. *A Comparative Review of Essential Health Benefits Pertinent to Children in Large Federal, State, and Small Group Health Insurance Plans: Implications for Selecting State Benchmark Plans.* Washington, DC: American Academy of Pediatrics. July 2012.

[4] *Kaiser Permanente for Small Business, Evidence of Coverage for Small Group Plan, January 1, 2012 - December 31, 2012.* Oakland, CA: Kaiser Foundation Health Plans, Inc. Northern California Region.

[5] *Covered California Standard Benefit Plan Designs, Summary of Benefits and Coverage. March 15, 2013.* Available at www.healthexchange.ca.gov. Accessed on April 1 and May 10, 2013.

[6] Senate Bill 951 introduced by Senator Hernandez on January 5, 2012 and amended on March 26 and April 16, 2012. Available at www.leginfo.ca.gov. Accessed on April 1, 2013.

[7] Assembly Bill 1453 introduced by Assembly Member Monning on January 5, 2012 and amended on March 29 and April 17, 2012. Available at www.leginfo.ca.gov. Accessed on April 2, 2013.

[8] Covered California, California Health Benefit Exchange. *2012-2013 Initial Qualified Health Plan Solicitation to Health Issuers.* Sacramento, CA: California Health Benefit Exchange, Final Release, November 16, 2012 and amended on December 28, 2012.

[9] Covered California, California Health Benefit Exchange. *Qualified Health Plan Contract for 2014*. Sacramento, CA: California Health Benefit Exchange, May 6, 2013.

[10] Bernstein W, Boozang P, Campbell P, Dutton M, Lam A, Manatt Health Solutions. *Implementing National Health Reform in California: Changes to Public and Private Insurance.* Oakland, CA: California Healthcare Foundation, June 2010.

[11] *Issue Brief: Interaction between California State Benefit Mandates and the Affordable Care Act's "Essential Health Benefits."* Oakland, CA: California Health Benefits Review Program, March 2012.

[12] Insurers may substitute their prescription drug formulary as long as coverage for prescription drugs complies with California mandated benefits.

[13] HHS' Final Rule on Standards Related to Essential Health Benefits confirms that plans in both the individual and small group markets are required to comply with the parity standards set forth in Section 146.136, implementing the requirements under the Mental Health Parity and Addiction Equity Act. In *Federal Register*, February 25, 2013.

[14] HHS' Final Rule on Standards Related to Essential Health benefits states that a plan must cover (1) one drug in every USP category and class, or (2) the same number of drugs in each category and class as the EHB-benchmark plan. In *Federal Register*, February 25, 2013.

[15] JJS' Final Rule on Standards Related to Essential Health Benefits states that a plan must (1) provide parity by covering habilitative services benefits that are similar in scope, amount, and duration to benefits covered for rehabilitative services, or (2) decide which habilitative services to cover and report on that coverage to HHS. In *Federal Register*, February 25, 2013.

[16] A detailed list of covered preventive services for children and women, including pregnant women is available at www.healthcare.gov. Accessed on April 1, 2013. The ACA requires coverage of preventive care and screenings for children and women provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. It also requires preventive health services with a rating of 'A' or 'B' in the current recommendations of the U.S. Preventive Services Task Force, and immunizations recommended from the CDC's Advisory Committee on Immunization Practices.

[17] States have the option of supplementing dental and vision benchmark coverage included in the FEDVIP dental plan with the largest enrollment or available under the state's separate CHIP program. In *Federal Register*, February 25, 2013.

[18] *Essential Health Benefits Bulletin*. HHS' Center for Consumer Information and Insurance Oversight. December 16, 2011.

[19] Kaiser defines an emergency medical condition as "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: placing the person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; serious dysfunction of any bodily organ or part. A medical health condition is an Emergency Medical Condition when it meets the requirements of the [statement] above, or when the condition manifests itself by acute symptoms of sufficient severity such that either of the following is true: the person is an immediate danger to himself or herself or to others; the person is immediately unable to provide for, or use, food, shelter, or clothing, due to the mental disorder."

Table 1. Coverage of Benefits in California's Exchange Standard Plans

BENEFITS	COVERAGE
1. AMBULATORY SERVICES	
- Primary Care Visit	Y
- Specialist Visit	Y
- Other Practitioner Visit[1]	Y
- Urgent Care	Y
2. PREVENTIVE AND WELLNESS SERVICES AND CHRONIC DISEASE MANAGEMENT	
- Preventive Care/Screening/Immunization	Y
- Health Education Counseling and Programs	Y
- Developmental Screening	Y
- Alcohol/Substance Abuse Screening	Y
- Family Planning Counseling	Y
- STD Preventive Counseling	Y
3. EMERGENCY SERVICES	
- Emergency Room Services	Y
- Medical Transportation	Y
4. HOSPITALIZATION	
- Inpatient Hospital Room Services	Y
- Inpatient Physician/Surgeon Services	Y
- Outpatient Surgery Facility Fee	Y
- Outpatient Surgery Physician/Surgeon Services	Y
5. MATERNITY AND NEWBORN CARE	
- Prenatal and Preconception Visits	Y[2]
- Inpatient Delivery Services	Y
- Inpatient Physician/Surgeon Services	Y
6. LABORATORY SERVICES	
- Laboratory Tests	Y
- X-rays and Diagnostic Imaging	Y
- Imaging (CT/PET Scans/MRIs)	Y
7. PRESCRIPTION DRUGS	
- Generic Drugs	Y
- Preferred Brand-Name Drugs	Y
- Non-Preferred Brand-Name Drugs	Y
- Specialty Drugs	Y
8. MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES, INCLUDING BEHAVIORAL HEALTH TREATMENT	
Outpatient Care – Mental Health	
- Psychological Testing	Y[3]

BENEFITS	COVERAGE
- Individual and Group Outpatient Therapy	Y
- Family Therapy	N
- Pharmacotherapy	Y
- Applied Behavioral Analysis	Y[4]
- Intensive Outpatient Psychiatric Treatment	L[5]
Inpatient Care – Mental Health	
- Inpatient Psychiatric Hospitalization	Y
- Crisis Residential Services	L[6]
Outpatient Care – Chemical Dependency	
- Individual/Group Chemical Dependency Therapy	Y
- Family Therapy	N
- Outpatient Medical Treatment for Withdrawal Symptoms	Y
- Intensive Outpatient Treatment	Y
- Methadone Maintenance	L[7]
Inpatient Care – Chemical Dependency	
- Inpatient Hospital Care	L[8]
- Residential Recovery Services	Y
9. REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES	
- Physical Therapy	Y
- Occupational Therapy	Y
- Speech Therapy	Y
- Habilitative Services	Y[9]
- Home Health Care	L[10]
- Private Duty Nursing	N
- Skilled Nursing Facility Care	L[11]
- Hospice Services	Y
- Durable Medical Equipment	Y[12]
- Medical Supplies	Y[12]
- Hearing Exams	Y
- Audiology Tests	N
- Hearing Aids	N
- Cochlear Implants	N
10. PEDIATRIC SERVICES, INCLUDING DENTAL AND VISION CARE	
Dental Care[13]	
- Periodic Dental Examinations	Y
- Prophylaxis	Y
- Fluoride Treatment	Y
- Radiographs (two bitewing, panoramic)	Y

BENEFITS	COVERAGE
- Sealants (permanent molar)	Y
- Two Surface Primary Tooth Composite Filling	Y
- One Surface Primary Tooth Composite Filling	Y
- Anterior Incisor Fracture Repair	Y
- Primary Tooth Stainless Steel Crown	Y
- Primary Tooth Extraction	Y
- Bilateral Fixed Space Maintainer	NS
- Orthodontics	L[14]
Vision Care[15]	
- Eye Exams	Y
- Glasses	L[16]
- Contact lenses	L[16]

Code: Y=Yes N=Not covered L=Limited NS=Not specified

Footnotes

[1] Other practitioner visits include physical, occupational, and speech therapy visits.
[2] Prenatal care includes regularly scheduled preventive prenatal care exams and the first follow-up preconception consultation and exam.
[3] Psychological testing is covered when necessary to evaluate a mental disorder.
[4] Behavioral health treatment for pervasive developmental disorder and autism is a California-mandated benefit and includes professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore the functioning of an individual with pervasive developmental disorder or autism.
[5] Intensive outpatient hospital care and multidisciplinary treatment in an outpatient psychiatric treatment program are covered on a short-term basis. No visit limits are applied.
[6] Crisis residential services are covered for short-term treatment in a licensed psychiatric treatment facility with 24-hour-a-day monitoring for stabilization of an acute psychiatric crisis. No visit limits are applied.
[7] Methadone maintenance is covered only for pregnant women during pregnancy and 2 months after delivery at an approved licensed treatment center.
[8] Inpatient hospital care for chemical dependency is limited to detoxification only.
[9] Habilitative services are covered under the same terms and conditions that apply to rehabilitative services. These services are defined as "medically necessary health care services and health care devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual's environment."
[10] Home health care is covered up to 2 hours/visit by a nurse, medical social worker, or physical, occupational, or speech therapist, and up to 4 hours/visit by a home health aide, up to 3 visits per day (counting all home health visits) and up to 100 visits/year (counting all home health visits).
[11] Skilled nursing facility care is covered up to 100 days per benefit period. A benefit period begins on the date admitted to hospital or skilled nursing facility at a skilled level of care. A benefit period ends on the date one has not been an inpatient in a hospital or skilled nursing facility receiving a skilled level of care for 60 consecutive days. A new benefit period can begin only after an existing benefit period ends. A prior 3-day stay in an acute care hospital is not required.
[12] Durable medical services and supplies are covered according to the plan's formulary.
[13] Pediatric dental coverage is offered through stand-alone plans.
[14] Orthodontia is available only for children 18 and under through California Children's Services Program when the condition meets program criteria for medically handicapping malocclusion.
[15] Pediatric vision coverage is offered through stand-alone plans.
[16] Lenses are limited to one per year and frames are limited to one every year. Contact lenses are covered only in lieu of glasses.

Table 2. Cost-Sharing Requirements in California's Exchange Standard Plans[1]

BENEFITS	MEMBER COST SHARING BY TYPE OF PLAN				
	Platinum	Gold	Silver	Bronze	Catastrophic
Actuarial Value	88.0%	78.0%	68.3%	60.4%	60.4%
Overall (Family) Deductible[2]	$0	$0	NA	$10,000	$12,800
Other (Family) Deductibles					
- Medical[3]	$0	$0	$4,000	NA	NA
- Brand-Name Drugs[4]	$0	$0	$500	NA	NA
Out-of-Pocket Limit on Expenses (Family)	$8,000	$12,800	$12,800	$12,800	$12,800
1. AMBULATORY SERVICES					
- Primary Care Visit	$20	$30	$45	$60Ⓓ[2,5]	$0Ⓓ[2,5]
- Specialist Visit	$40	$50	$65	$70Ⓓ[2]	$0Ⓓ[2]
- Other Practitioner Visit	$20	$30	$45	$60Ⓓ[2]	$0Ⓓ[2]
- Urgent Care	$40	$60	$90	$120Ⓓ[2,5]	$0Ⓓ[2,5]
2. PREVENTIVE AND WELLNESS SERVICES AND CHRONIC DISEASE MANAGEMENT					
- Preventive Care/Screening Immunization	None	None	None	None	None
- Health Education Preventive Counseling	None	None	None	None	None
- Developmental Screening	None	None	None	None	None
- Alcohol/Substance Abuse Screening	None	None	None	None	None
- Family Planning Counseling	None	None	None	None	None
- STD Preventive Counseling	None	None	None	None	None
3. EMERGENCY SERVICES					
- Emergency Room Services[6]	$150	$250	$250Ⓓ[3]	$300Ⓓ[2]	$0Ⓓ[2]
- Medical Transportation	$150	$250	$250Ⓓ[3]	$300Ⓓ[2]	$0Ⓓ[2]
4. HOSPITALIZATION					
- Inpatient Hospital Room Services	$250/day up to 5 days	$600/day up to 5 days	20%Ⓓ[3]	30%Ⓓ[2]	$0Ⓓ[2]
- Inpatient Physician/Surgeon Services					
- Outpatient Surgery Facility Fee	$250	$600	20%Ⓓ[3]	30%Ⓓ[2]	$0Ⓓ[2]
- Outpatient Surgery Physician/Surgeon Services			20%		

BENEFITS	MEMBER COST SHARING BY TYPE OF PLAN				
	Platinum	Gold	Silver	Bronze	Catastrophic
5. MATERNITY AND NEWBORN CARE					
- Prenatal Care and Preconception Visits	None	None	None	None	None
- Inpatient Delivery Services	$250/day up to 5 days	$600/day up to 5 days	20%Ⓓ[3]	30%Ⓓ[2]	$0Ⓓ[2]
- Inpatient Physician/Surgeon Services					
6. LABORATORY SERVICES					
- Lab Tests	$20	$30	$45	30%Ⓓ[2]	$0Ⓓ[2]
- X-Rays and Diagnostic Imaging	$40	$50	$65	30%Ⓓ[2]	$0Ⓓ[2]
- Imaging (CT/PET Scans/MRI)	$150	$250	$250	30%Ⓓ[2]	$0Ⓓ[2]
7. PRESCRIPTION DRUGS					
- Generic Drugs	$5	$20	$25	$25Ⓓ[2]	$0Ⓓ[2]
- Preferred Brand-Name Drugs	$15	$50	$50Ⓓ[4]	$50Ⓓ[2]	$0Ⓓ[2]
- Non-Preferred Brand-Name Drugs	$25	$70	$70Ⓓ[4]	$75Ⓓ[2]	$0Ⓓ[2]
- Specialty Drugs	10%	20%	20%Ⓓ[4]	30%Ⓓ[2]	$0Ⓓ[2]
8. MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES, INCL. BEHAVIORAL HEALTH TREATMENT					
- Psychological Testing	NS	NS	NS	NS	NS
- Mental Health/Behavioral Health Outpatient Services	$20	$30	$45	$60Ⓓ[2]	$0Ⓓ[2]
- Mental/Behavioral Health Inpatient Services	$250/day up to 5 days	$600/day up to 5 days	20%Ⓓ[3]	30%Ⓓ[2]	$0Ⓓ[2]
- Substance Use Disorder Outpatient Services	$20	$30	$45	$60Ⓓ[2]	$0Ⓓ[2]
- Substance Use Disorder Inpatient Services	$250/day up to 5 days	$600/day up to 5 days	20%Ⓓ[3]	30%Ⓓ[2]	$0Ⓓ[2]
9. REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES					
- Rehabilitative Services	$20	$30	$45	30%Ⓓ[2]	$0Ⓓ[2]
- Habilitative Services	$20	$30	$45	30%Ⓓ[2]	$0Ⓓ[2]
- Home Health Care	$20	$30	$45	30%Ⓓ[2]	$0Ⓓ[2]
- Durable Medical Equipment/Medical Supplies	10%	20%	20%	30%Ⓓ[2]	$0Ⓓ[2]
- Skilled Nursing Facility Care	$150/day up to 5 days	$300/day up to 5 days	20%Ⓓ[3]	30%Ⓓ[2]	$0Ⓓ[2]
- Hospice Care	None	None	None	None	None

BENEFITS	MEMBER COST SHARING BY TYPE OF PLAN			
	PPO High Option	PPO Low Option	HMO High Option	HMO Low Option
10. PEDIATRIC SERVICES, INCLUDING DENTAL AND VISION CARE				
Dental Care				
Actuarial Value	86%	72%	87%	72%
Deductible[7]	$50[7]	$60	$0	$0
Out-of-Pocket Limit on Expenses[9]	$1,000	$1,000	$1,000	$1,000
- Periodic Dental Exams	None	None	None	None
- Prophylaxis	None	None	None	None
- Fluoride Treatment	None	None	None	None
- Radiographs (2 bitewing panoramic)	None	None	None	None
- Sealants (Permanent Molar)	None	None	None	None
- Office Visits	NS	NS	None	$20
- Two Surface Primary Tooth Composite Filling	20%	50%	$40[10]	$95[10]
- One Surface Primary Tooth Composite Filling	20%	50%	$40[10]	$95[10]
- Anterior Incisor Fracture Repair	20%	50%	$40[10]	$95[10]
- Primary Tooth Stainless Steel Crown	50%	50%	$365[11]	$365[11]
- Bilateral Fixed Space Maintainer	NS	NS	NS	NS
- Orthodontics[12]	50%	50%	$1,000	$1,000
Vision Care				
Actuarial Value	NS	NS	NS	NS
Deductible	NS	NS	NS	NS
Out-of-Pocket Limit on Expenses	NS	NS	NS	NS
- Eye Exams	None	None	None	None
- Glasses	NS	NS	NS	NS

Code: NA=Not applicable NS=Not specified Ⓓ=Deductible applies

---

Footnotes

[1] This table compares co-pay plans, not co-insurance or HSA plans. Not included in this table is information on small business health option programs (SHOP). Information on co-insurance and HSA plans for individuals and for SHOP plans can be found at www.healthexchange.ca.gov.

[2] The services for which the overall deductible applies is marked in the table byⒹ[2].

[3] The services for which only the medical deductible applies is marked in the table byⒹ[3].

[4] The services for which only the drug deductible applies is marked in the table by Ⓓ[4].

[5] The deductible applies after the first 3 non-preventive visits.

[6] Emergency fees are waived if admitted to the hospital.

[7] Deductibles accrue on a per-child basis and no child is responsible for more than $1,000 in out-of-pocket costs.

[8] The dental deductible does not apply to diagnostic and preventive services, including exams, cleanings, x-rays, and sealants.

[9] If 2 or more children are enrolled in a single pediatric plan, the out-of-pocket maximum is doubled, but for any single child it cannot exceed $1,000.

[10] This co-pay amount represents the plan's average co-pay charged for these basic restorative services and cannot exceed the stated amount.

[11] This co-pay amount represents the plan's average co-pay charged for these major services and cannot exceed the stated amount.

[12] Orthodontia is available only for children 18 and under through California Children's Services Program when the condition meets program criteria for medically handicapping malocclusion.

Table 3. Cost Sharing in the Subsidized Silver Co-Pay Exchange Standard Plans by Poverty Level[1]

BENEFITS	100% FPL - 150% FPL ($19,530 - $29,295)[1]	150% FPL - 200% FPL ($29,295 - $39,060)[1]	200% FPL - 250% FPL ($39,060 - $48,825)[1]
Actuarial Value	94.9%	87.7%	73.3%
Overall (Family) Deductible[2]	$0	NA	NA
Other (Family) Deductible			
- Medical[3]	$0	$1,000	$3,000
- Brand-Name Drugs[4]	$0	$100	$500
Out-of-Pocket Limit on Expenses (Family)	$4,500	$4,500	$10,400
1. AMBULATORY SERVICES			
- Primary Care Visit	$3	$15	$40
- Specialist Visit	$5	$20	$50
- Other Practitioner Visit	$3	$15	$40
- Urgent Care	$6	$30	$80
2. PREVENTIVE AND WELLNESS SERVICES AND CHRONIC DISEASE MANAGEMENT			
- Preventive Care/Screening Immunization	None	None	None
- Health Education Preventive Counseling	None	None	None
- Developmental Screening	None	None	None
- Family Planning Counseling	None	None	None
- Alcohol/Substance Abuse Screening	None	None	None
3. EMERGENCY SERVICES			
- Emergency Room Services[5]	$25	$75Ⓓ[3]	$250Ⓓ[3]
- Medical Transportation	$25	$75Ⓓ[3]	$250Ⓓ[3]
4. HOSPITALIZATION			
- Inpatient Hospital Room Services	10%	15%Ⓓ[3]	20%Ⓓ[3]
- Inpatient Physician/Surgeon Services	10%	15%Ⓓ[3]	20%Ⓓ[3]
- Outpatient Surgery Facility Fee	10%	15%Ⓓ[3]	20%Ⓓ[3]
- Outpatient Surgery Physician/Surgeon Services	10%	15%	20%
5. MATERNITY AND NEWBORN CARE			
- Prenatal and Preconception Visits	None	None	None
- Inpatient Delivery Services	10%	15%Ⓓ[3]	20%Ⓓ[3]
- Inpatient Physician/Surgeon Services	10%	15%Ⓓ[3]	20%Ⓓ[3]

BENEFITS	100% FPL - 150% FPL ($19,530 - $29,295)[1]	150% FPL - 200% FPL ($29,295 - $39,060)[1]	200% FPL - 250% FPL ($39,060 - $48,825)[1]
6. LABORATORY SERVICES			
- Lab Tests	$3	$15	$40
- X-Rays and Diagnostic Imaging	$5	$20	$50
- Imaging (CT/PET Scans/MRISs)	$50	$100	$250
7. PRESCRIPTION DRUGS			
- Generic Drugs	$3	$5	$20
- Preferred Brand-Name Drugs	$5	$15Ⓓ[4]	$30Ⓓ[4]
- Non-Preferred Brand-Name Drugs	$10	$25Ⓓ[4]	$50Ⓓ[4]
- Specialty Drugs	10%	15%Ⓓ[4]	20%Ⓓ[4]
8. MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES, INCLUDING BEHAVIORAL HEALTH TREATMENT			
- Mental Health/Behavioral Health Outpatient Services	$3	$15	$40
- Mental/Behavioral Inpatient Services	10%	15%Ⓓ[3]	20%Ⓓ[3]
- Substance Use Disorder Outpatient Services	$3	$15	$40
- Substance Use Disorder Inpatient Services	10%	15%Ⓓ[3]	20%Ⓓ[3]
9. REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES			
- Rehabilitation Services	$3	$15	$40
- Habilitation Services	$3	$15	$40
- Home Health Care	$3	$15	$40
- Durable Medical Equipment/Medical Supplies	10%	15%	20%
- Skilled Nursing Facility Care	10%	15%Ⓓ[3]	20%Ⓓ[3]
- Hospice Care	None	None	None
10. PEDIATRIC SERVICES, INCLUDING DENTAL AND VISION CARE[6]			

Code: NA=Not applicable NS=Not specified Ⓓ=Deductible applies

---

Footnotes

[1] The federal poverty level (FPL) information reported in this table is for a family of three.

[2] The services for which the overall deductible applies is marked in the table byⒹ[2].

[3] The services for which only the medical deductible applies is marked in the table byⒹ[3].

[4] The services for which only the drug deductible applies is marked in the able by Ⓓ[4].

[5] Emergency fees are waived if admitted to the hospital.

[6] Dental and vision cost-sharing subsidy information was not available to authors.

Table 4. Summary of California's Mandated Benefits Pertaining to Children and Adolescents

Preventive Services for Children
▪ Coverage of Preventive Health Services, consistent with the ACA, includes US Preventive Services Task Force (USPSTF) services that have a rating of 'A' or 'B,' immunizations recommended by the Advisory Committee on Immunization Practices (ACIP), evidence-informed preventive care and screenings in guidelines supported by the Health Resources and Services Administration (HRSA), and additional preventive care and screenings for women in guidelines supported by HRSA. (Section 1367.002) ▪ Coverage of Pediatric Asthma-Related Management and Treatment includes medically necessary inhaler spacers; nebulizers, including face masks and tubing; peak flow meters; and education for pediatric asthma. (Section 1367.06)
Prescription Drug Coverage for Contraceptives
▪ Coverage of FDA-Approved Prescription Contraceptive Methods.(Section 1367.25)
HIV Testing
▪ Coverage of Human Immunodeficiency Virus (HIV) Testing, regardless of whether the testing is related to a primary diagnosis. (Section 1367.46)
Diabetes Management and Treatment
▪ Coverage of Equipment and Supplies for the Management and Treatment of Diabetes, includes blood glucose monitors and blood glucose testing strips, blood glucose monitors designed to assist the visually impaired, insulin pumps and all related necessary supplies, ketone urine testing strips, lancets and lance puncture devices, pen delivery systems for the administration of insulin, podiatric devices to prevent or treat diabetes-related complications, insulin syringes, visual aids to assist the visually impaired with proper dosing of insulin. Also coverage includes insulin, prescription medications for the treatment of diabetes, glucagon, and self-management training, education, and medical nutrition therapy. (Section 1367.51)
Reconstructive Surgery
▪ Coverage for Reconstructive Surgery includes surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, including cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate, in order to improve function and create a normal appearance, to the extent possible. (Section 1367.63)
Cervical Cancer Screening
▪ Coverage for Cervical Cancer Screening Test include Pap test, HPV test, and the option of any other FDA-approved cervical cancer screening test. (Section 1367.66)
Anesthesia for Dental Procedures
▪ Coverage for General Anesthesia and Associated Facility Charges for Dental Procedures in a hospital or surgery center setting when the patient requires dental procedures that ordinarily would not require general anesthesia in a hospital or surgery center. These enrollees must be either under the age of 7, be developmentally disabled regardless of age, or have a compromised health condition for whom general anesthesia is medically necessary regardless of age. (Section 1367.71)

Cancer Clinical Trials

- Coverage for Routine Patient Care Costs Related to Clinical Trial (Phases I-IV) if the enrollee's treating physician, who is providing covered health care services to the enrollee recommends participation in the clinical trial after determining that participation has a meaningful potential to benefit the enrollee. (Section 1370.6)

Phenylketonuria Testing and Treatment

- Coverage for Hospital, Medical, or Surgical Expenses for Testing and Treatment of Phenylketonuria (PKU) includes formulas and special food products that are part of a diet prescribed by a licensed physician and managed by a health care professional in consultation with a physician who specializes in the treatment of metabolic disease and who participates in or is authorized by the plan, provided that the diet is medically necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU. (Section 1374.56)

Mental Health Parity

- Coverage for Diagnosis and Medically Necessary Treatment of Severe Mental Illnesses of a Person of Any Age and of Serious Emotional Disturbances of a Child Under the Same Terms and Conditions Applied to Other Medical Conditions. These benefits include outpatient services, inpatient hospital services, partial hospital services, prescription drugs (if the plan includes it). The terms and conditions include, but are not limited to maximum lifetime benefits, co-payments, and individual and family deductibles. Severe mental illnesses include schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa. A child suffering from "serious emotional disturbances of a child" is defined as a child who (1) has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms, and (2) who meets the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code. (Section 1374.72)

Behavioral Health Treatment for Pervasive Developmental Disability and Autism

- Coverage for Behavioral Health Treatment for Pervasive Developmental Disorder or Autism includes professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore the functioning of an individual with pervasive developmental disorder or autism that meets all of the following criteria: A) the treatment is prescribed by a licensed physician and surgeon or is developed by a licensed psychologist; B) the treatment is provided under a treatment plan prescribed by a qualified autism service provider and is administered by either a qualified autism service provider, qualified autism service professional supervised and employed by the qualified autism service provider, or qualified autism service paraprofessional supervised and employed by a qualified autism service provider; C) the treatment plan has measurable goals over a specific timeline that is developed and approved by the qualified autism provider. The treatment plan shall be reviewed no less than once every 6 months by the qualified autism provider and modified whenever appropriate and shall i) describe the patient's behavioral health impairments to be treated, ii) design an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported, iii) provide intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism, and iv) discontinue intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate. The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. (Section 1374.73)

Table 5. Comparison of Private Benchmark Plan and Medi-Cal and EPSDT for Children Under 21

BENEFITS	BENCHMARK COVERAGE	MEDI-CAL & EPSDT
1. AMBULATORY SERVICES		
- Primary Care Visit	Y	Y
- Specialist Visit	Y	Y
- Other Practitioner Visit[1]	Y	Y
- Urgent Care	Y	Y
2. PREVENTIVE AND WELLNESS SERVICES AND CHRONIC DISEASE MANAGEMENT		
- Preventive Care/Screening/Immunization	Y	Y
- Health Education Counseling	Y	Y
- Developmental Screening	Y	Y
- Alcohol/Substance Abuse Screening	Y	Y
- Family Planning Counseling	Y	Y
- STD Preventive Counseling	Y	Y
3. EMERGENCY SERVICES		
- Emergency Room Services	Y	Y
- Medical Transportation	Y	Y
4. HOSPITALIZATION		
Inpatient Care		
- Hospital Room	Y	Y
- Physician/Surgeon Services	Y	Y
Outpatient Care		
- Outpatient Facility Services	Y	Y
- Physician/Surgeon Services	Y	Y
5. MATERNITY AND NEWBORN CARE		
- Prenatal and Preconception Visits	Y[2]	Y
- Inpatient Delivery Services	Y	Y
- Inpatient Physician/Surgeon Services	Y	Y
6. LABORATORY SERVICES		
- Laboratory Tests	Y	Y
- X-rays and Diagnostic Imaging	Y	Y
- Imaging (CT/PET Scans/MRIs)	Y	Y
7. PRESCRIPTION DRUGS		
- Generic Drugs	Y	Y
- Preferred Brand-Name Drugs	Y	Y
- Non-Preferred Brand-Name Drugs	Y	Y
- Specialty Drugs	Y	Y
8. MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES, INCLUDING BEHAVIORAL HEALTH TREATMENT		
Outpatient Care – Mental Health		

BENEFITS	BENCHMARK COVERAGE	MEDI-CAL & EPSDT
- Psychological Testing	Y[3]	Y
- Individual and Group Outpatient Therapy	Y	Y
- Family Therapy	N	L[4]
- Pharmacotherapy	Y	Y
- Applied Behavioral Analysis	Y[5]	Y
- Intensive Outpatient Psychiatric Treatment	L[6]	L[4]
Inpatient Care – Mental Health		
- Inpatient Psychiatric Hospitalization	Y	Y
- Crisis Residential Services	L[7]	L[4]
Outpatient Care – Chemical Dependency		
- Individual/Group Chemical Dependency Therapy	Y	Y
- Family Therapy	N	L[4]
- Outpatient Medical Treatment for Withdrawal Symptoms	Y	Y
- Intensive Outpatient Treatment	Y	L[4]
- Methadone Maintenance	L[8]	L[4]
Inpatient Care – Chemical Dependency		
- Inpatient Hospital Care	L[9]	Y
- Residential Recovery Services	Y	L[4]
9. REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES		
- Physical Therapy	Y	Y
- Occupational Therapy	Y	Y
- Speech Therapy	Y	Y
- Habilitative Services	Y[10]	Y
- Home Health Care	L[11]	Y
- Private Duty Nursing	N	Y
- Skilled Nursing Facility Care	L[12]	Y
- Hospice Services	Y	Y
- Durable Medical Equipment	Y[13]	Y
- Medical Supplies	Y[13]	Y
- Hearing Exams	Y	Y
- Audiology Tests	N	Y
- Hearing Aids	N	L[14]
- Cochlear Implants	N	L[14]
10. PEDIATRIC SERVICES, INCLUDING DENTAL AND VISION CARE		
Dental Care[15]		
- Periodic Dental Examinations	Y	Y
- Prophylaxis	Y	Y
- Fluoride Treatment	Y	Y
- Radiographs (two bitewing, panoramic)	Y	Y
- Sealants (permanent molar)	Y	Y

BENEFITS	BENCHMARK COVERAGE	MEDI-CAL & EPSDT
Restorative		
- Two Surface Primary Tooth Composite Filling	Y	Y
- One Surface Primary Tooth Composite Filling	Y	Y
- Anterior Incisor Fracture Repair	Y	Y
- Primary Tooth Stainless Steel Crown	Y	Y
- Primary Tooth Extraction	Y	Y
- Bilateral Fixed Space Maintainer	NS	Y
- Orthodontics	L[16]	L[16]
Vision Care[17]		
- Eye Exams	Y	L[18]
- Glasses	L[19]	Y
- Contact lenses	L[19]	Y

Code: Y=Yes N=Not covered L=Limited NS=Not specified

Footnotes

[1] Other practitioner visits include physical, occupational, and speech therapy visits.
[2] Prenatal care includes regularly scheduled preventive prenatal care exams and the first follow-up preconception consultation and exam.
[3] Psychological testing is covered when necessary to evaluate a mental disorder.
[4] Family therapy is covered for children and adolescents with serious emotional disturbances who are eligible for California Department of Mental Health services.
[5] Behavioral health treatment for pervasive developmental disorder and autism is a California-mandated benefit and includes professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore the functioning of an individual with pervasive developmental disorder or autism.
[6] Intensive outpatient hospital care and multidisciplinary treatment in an outpatient psychiatric treatment program are covered on a short-term basis. No visit limits are applied.
[7] Crisis residential services are covered for short-term treatment in a licensed psychiatric treatment facility with 24-hour-a-day monitoring for stabilization of an acute psychiatric crisis. No visit limits are applied.
[8] Methadone maintenance is covered only for pregnant women during pregnancy and 2 months after delivery at an approved licensed treatment center.
[9] Inpatient hospital care for chemical dependency is limited to detoxification only.
[10] Habilitative services are covered under the same terms and conditions that apply to rehabilitative services. These services are defined as "medically necessary health care services and health care devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual's environment."
[11] Home health care is covered up to 2 hours/visit by a nurse, medical social worker, or physical, occupational, or speech therapist, and up to 4 hours/visit by a home health aide, up to 3 visits per day (counting all home health visits) and up to 100 visits/year (counting all home health visits).
[12] Skilled nursing facility care is covered up to 100 days per benefit period. A benefit period begins on the date admitted to hospital or skilled nursing facility at a skilled level of care. A benefit period ends on the date one has not been an inpatient in a hospital or skilled nursing facility receiving a skilled level of care for 60 consecutive days. A new benefit period can begin only after an existing benefit period ends. A prior 3-day stay in an acute care hospital is not required.
[13] Durable medical services and supplies are covered according to the plan's formulary.
[14] Hearing aids and cochlear implants are covered for those who are eligible for California Children's Services Program.
[15] Pediatric dental coverage is offered through stand-alone plans.
[16] Orthodontia is available only for children 18 and under through California Children's Services Program when the condition meets program criteria for medically handicapping malocclusion.
[17] Pediatric vision coverage is offered through stand-alone plans.
[18] Routine eye exams with refraction are limited to one service in a 24-month period.
[19] Lenses are limited to one per year and frames are limited to one every year in the high option plan and every other year in the standard or low option plan. Contact lenses are covered only in lieu of glasses

United States Government Accountability Office

Report to Ranking Member, Committee on the Judiciary, U.S. Senate

April 2013

HEALTH INSURANCE

Seven States' Actions to Establish Exchanges under the Patient Protection and Affordable Care Act

GAO-13-486

April 2013

HEALTH INSURANCE

Seven States' Actions to Establish Exchanges under the Patient Protection and Affordable Care Act

Highlights of GAO-13-486, a report to the Ranking Member, Committee on the Judiciary, U.S. Senate

Why GAO Did This Study

A central provision of PPACA requires the establishment of exchanges in each state—online marketplaces through which eligible individuals and small business employers can compare and select health insurance coverage from participating health plans. Exchanges are to begin enrollment by October 1, 2013, with coverage to commence January 1, 2014. States have some flexibility with respect to exchanges by choosing to establish and operate an exchange themselves (i.e., state-based), or by ceding this authority to HHS (i.e., federally facilitated). States may also choose to enter into a partnership with HHS whereby HHS establishes the exchange and the state assists with operating various functions. According to HHS, 18 states will establish a state-based exchange, while 26 will have a federally facilitated exchange. Seven states will partner with HHS.

GAO was asked to report on (1) states' responsibilities for establishing exchanges, and (2) actions selected states have taken to establish exchanges and challenges they have encountered. To do this work, GAO reviewed PPACA provisions and HHS implementing regulations and guidance. GAO also conducted semistructured interviews with state officials in the District of Columbia, Iowa, Minnesota, Nevada, New York, Oregon, and Rhode Island. For this review, GAO refers to the District of Columbia as a state. GAO selected these states based on several criteria, such as a 3-year average of states' uninsured population and geographic dispersion. HHS and the seven states in our review provided technical comments on this report, which GAO incorporated as appropriate.

View GAO-13-486. For more information, contact Stanley J. Czerwinski at (202) 512-6806 or czerwinskis@gao.gov.

What GAO Found

The Patient Protection and Affordable Care Act (PPACA) and the Department of Health and Human Services (HHS) regulations, supplemented by HHS guidance, require states and American Health Benefit Exchanges (exchanges) to carry out a number of key functions, for which state responsibilities vary by exchange type. A state that chooses to operate its exchange is responsible for: (1) establishing an operating and governance structure, (2) ensuring exchanges are capable of certifying qualified health plans and making them available to qualified individuals, (3) developing electronic, streamlined, and coordinated eligibility and enrollment systems, (4) conducting consumer outreach and assistance, and (5) ensuring the financial sustainability of the exchange. A state that partners with HHS may assist HHS with certain functions, such as making qualified health plan recommendations and conducting aspects of consumer outreach and assistance.

Despite some challenges, the seven selected states in GAO's review reported they have taken actions to create exchanges, which they expect will be ready for enrollment by the deadline of October 1, 2013. For example:

- Six states will operate as a state-based exchange, with most choosing this option as a way to maintain control of their insurance markets and better meet the needs of their state's residents. The seventh state—Iowa—will partner with HHS.
- All seven states have taken steps toward deciding which qualified health plans would be included in the exchange. Two states have decided that their exchanges will have the authority to actively select which qualified health plans may participate in the exchange, while the remaining five states will allow all qualified health plans to participate in the exchange.
- All states are in various stages of developing an information technology (IT) infrastructure, including redesigning, upgrading, or replacing their outdated Medicaid and Children's Health Insurance Program eligibility and enrollment systems. Six states are also building the exchange IT infrastructure needed to integrate systems and allow consumers to navigate among health programs, but identified challenges with the complexity and magnitude of the IT projects, time constraints, and guidance for developing their systems.
- Six of the seven states included in our review are in various stages of developing a consumer outreach and assistance program to reach out to and help enroll potential consumers. As a partnership state, Iowa has not yet decided whether and to what extent it will assume responsibility for aspects of this function.
- Officials in the six state-based exchanges reported they are considering revenue options for financially sustaining their exchange. For example, three states plan to charge fees to insurance carriers participating in the exchange. However, some states reported challenges with developing these options, given uncertainties related to exchange enrollment, on which the fees are based.

Contents

Abbreviations

BHP	Basic Health Program
CBO	Congressional Budget Office
CCIIO	Center for Consumer Information and Insurance Oversight
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
EHB	essential health benefits
HCERA	Health Care Education and Reconciliation Act
HHS	U.S. Department of Health and Human Services
IT	information technology
PPACA	Patient Protection and Affordable Care Act
QHP	Qualified Health Plan
SNAP	Supplemental Nutrition Assistance Program
TANF	Temporary Assistance for Needy Families

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

April 30, 2013

The Honorable Charles E. Grassley
Ranking Member
Committee on the Judiciary
United States Senate

Dear Senator Grassley:

The Patient Protection and Affordable Care Act (PPACA),[1] signed into law on March 23, 2010, contains a number of provisions intended to reform aspects of the private health insurance market and expand the availability and affordability of coverage. A central provision of the law requires the establishment of American Health Benefit Exchanges (exchanges) in each state—online marketplaces through which eligible individuals and small business employers can compare and select health insurance coverage from among participating health plans.[2] Intended to provide seamless "no wrong door" access to coverage options, in general, exchanges will need to be able to determine whether individuals and small business employees[3] are eligible for a private health plan, Medicaid,[4] or the Children's Health Insurance Program (CHIP).[5],[6] This

[1]Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010) (PPACA), as amended by the Health Care and Education Reconciliation Act, (HCERA) Pub. L. No. 111-152,124 Stat.1029 (Mar. 30, 2010). In this report, references to PPACA include any amendments made by HCERA.

[2]Pub. L. No. 111-148, § 1311(b), 124 Stat. at 173.

[3] PPACA requires the establishment of a Small Business Health Options Program, or SHOP—exchanges where small employers can shop for and purchase coverage for their employees. Under PPACA, until 2016, states have the option to define "small employers" either as those with 100 or fewer employees or 50 or fewer employees. Beginning in 2016, small employers will be defined as those with 100 or fewer employees. Beginning in 2017, states may allow large employers to obtain coverage through an exchange (but will not be required to do so). For purposes of our review, we did not include SHOP exchanges in the scope of our work.

[4]Medicaid is a joint federal-state program that finances health care coverage for certain categories of low-income individuals.

[5]CHIP is a federal-state program which provides health care coverage to children 18 years of age and younger living in low-income families whose incomes exceed the eligibility requirements for Medicaid.

[6] Pub. L. No. 111-148, § 1413(c), 124 Stat. at 234.

means that no matter how an individual submits an application or which program receives the application, there will be a process by which the individual can receive an eligibility determination using the same application, without the need to submit information to multiple programs. Exchanges are to begin enrollment by October 1, 2013, with coverage to commence January 1, 2014. The Congressional Budget Office has estimated that about 7 million individuals will be enrolled in exchanges in 2014, increasing to about 26 million by 2022.

While PPACA places some requirements on the design and function of exchanges, states also have a number of operational decisions to make. A state may establish the exchange itself (referred to as a state-based exchange), cede the responsibility entirely to the Department of Health and Human Services (HHS) (referred to as a federally facilitated exchange), or enter into a partnership with HHS (referred to as a partnership exchange).[7] Depending on the type of exchange, states are facing a number of critical policy and implementation decisions, subject to HHS regulation and approval. Such decisions involve determining individuals' eligibility and enrolling them in health insurance plans, conducting consumer outreach and assisting potential enrollees, ensuring qualified health plans are certified, and ensuring the exchange's long-term financial sustainability. In addition, states must develop information technology (IT) systems that securely facilitate the movement of information to provide enrollees with answers about their eligibility and enhance their ability to enroll in health insurance coverage. States are faced with unprecedented levels of data sharing and coordination between federal agencies, private health plans, state insurance commissioners, and state Medicaid agencies. As of March 27, 2013, the federal government has awarded states nearly $3.7 billion in grant funding to cover some of the states' planning and implementation costs.

You asked us to report on the actions states are taking to establish exchanges. This report addresses the following questions:

1. What are states' responsibilities for establishing exchanges?

[7]A partnership exchange is a variation of a federally facilitated exchange. HHS will establish and operate this type of exchange with states assisting HHS to carry out certain functions of that exchange.

2. What actions have selected states taken to establish exchanges and what challenges have they encountered?

To identify states' responsibilities for establishing exchanges, we reviewed selected PPACA provisions and HHS implementing regulations and guidance related to the following categories of responsibilities:[8]

- establishing a governance and operating structure;
- ensuring exchanges will be capable of certifying qualified health plans;
- simplifying and streamlining eligibility and enrollment systems;
- conducting consumer assistance and outreach; and
- ensuring financial sustainability of the exchange.

During our review, we obtained status updates on the development of regulations and guidance from the Center for Consumer Information and Insurance Oversight (CCIIO) within HHS's Centers for Medicare & Medicaid Services (CMS) that oversees the implementation of exchanges. We also met with CCIIO officials to discuss the ways in which they provided guidance to the states.

To identify the actions selected states have taken to establish exchanges and the challenges they encountered, we conducted semi-structured interviews with state exchange officials in the District of Columbia and six states: Iowa, Minnesota, Nevada, New York, Oregon, and Rhode Island. For the purposes of this report, we hereafter refer to the District of Columbia as a state. We selected these states on the basis of: (1) a 3-year average of the uninsured population within states; (2) the uninsured population in states in 2011; (3) the amount of federal exchange grants awarded to states on a per capita basis; (4) geographic dispersion, and (5) whether states will have a state-based, federally facilitated, or partnership exchange.[9] Six states in our review plan to establish and operate a state-based exchange, while one state—Iowa—opted for a partnership exchange. We also met with budget officials in some of these

[8]For purposes of this report, we focused on certain categories of responsibilities. Therefore, this list does not include all states' responsibilities related to creating and operating an exchange.

[9] Specifically, we selected states on the basis of whether they intended to establish a state-based, federally facilitated, or partnership exchange, as of September 27, 2012. At that time, states had not yet formally declared their intention to HHS. We used the most readily available information at that time from HHS and the Kaiser Family Foundation.

states to discuss the fiscal aspects of establishing exchanges, including how states will ensure financial sustainability for their exchange. The findings from these interviews cannot be generalized to all state exchange and budget offices. We obtained additional information from interviews with officials from state associations, including the National Association of Insurance Commissioners, the National Association of State Budget Officers, and the National Conference of State Legislatures. Two states that will have federally facilitated exchanges—Florida and Maine—were initially selected for inclusion in our review. However, exchange officials in those states declined to be interviewed. Therefore, this review focuses on states' responsibilities and actions related to state-based and partnership exchanges. A more detailed description of our objectives, scope, and methodology is included in appendix I.

We conducted our work from September 2011 to April 2013 in accordance with generally accepted government audit standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Exchanges are online marketplaces where eligible individuals and small businesses can purchase health insurance. PPACA prescribes a seamless, streamlined eligibility process for consumers to submit a single application and receive an eligibility determination for enrollment in a qualified health plan through the exchange, advance payments of the

premium tax credit,[10] cost sharing reductions,[11] Medicaid, CHIP, and the Basic Health Program (BHP),[12] if applicable.

Under PPACA, an exchange must be operational in each state by January 1, 2014. States have some flexibility with respect to exchanges, by choosing to establish and operate an exchange themselves (referred to as a state-based exchange) or by ceding this authority to HHS (referred to as a federally facilitated exchange).[13] States choosing to establish a state-based exchange were required to submit an application "blueprint" to HHS by December 14, 2012. Subject to HHS review and approval, the blueprint detailed how the states planned to implement various functions and activities that HHS deemed essential to operating this type of exchange. HHS identified a third type of exchange states

[10]Beginning on January 1, 2014, a premium tax credit will be available to help eligible tax filers and their dependents pay for qualified health plans purchased through PPACA exchanges. The premium tax credit is available on an advance basis, referred to as advance payments of the premium tax credit, and any advance payments are reconciled on a tax filer's tax return. Ultimately, tax credits will be calculated using income reported on tax returns. The credits will generally be available to eligible tax filers and their dependents who are (1) enrolled in one or more qualified health plans through an exchange, and (2) not eligible for other health insurance coverage. More specifically, to qualify for the premium tax credit, an individual or family must generally have income between 100 and 400 percent of the federal poverty level and not qualify for other health care coverage, such as Medicare, Medicaid, or employer-sponsored coverage that meets a minimum value standard specified in PPACA.

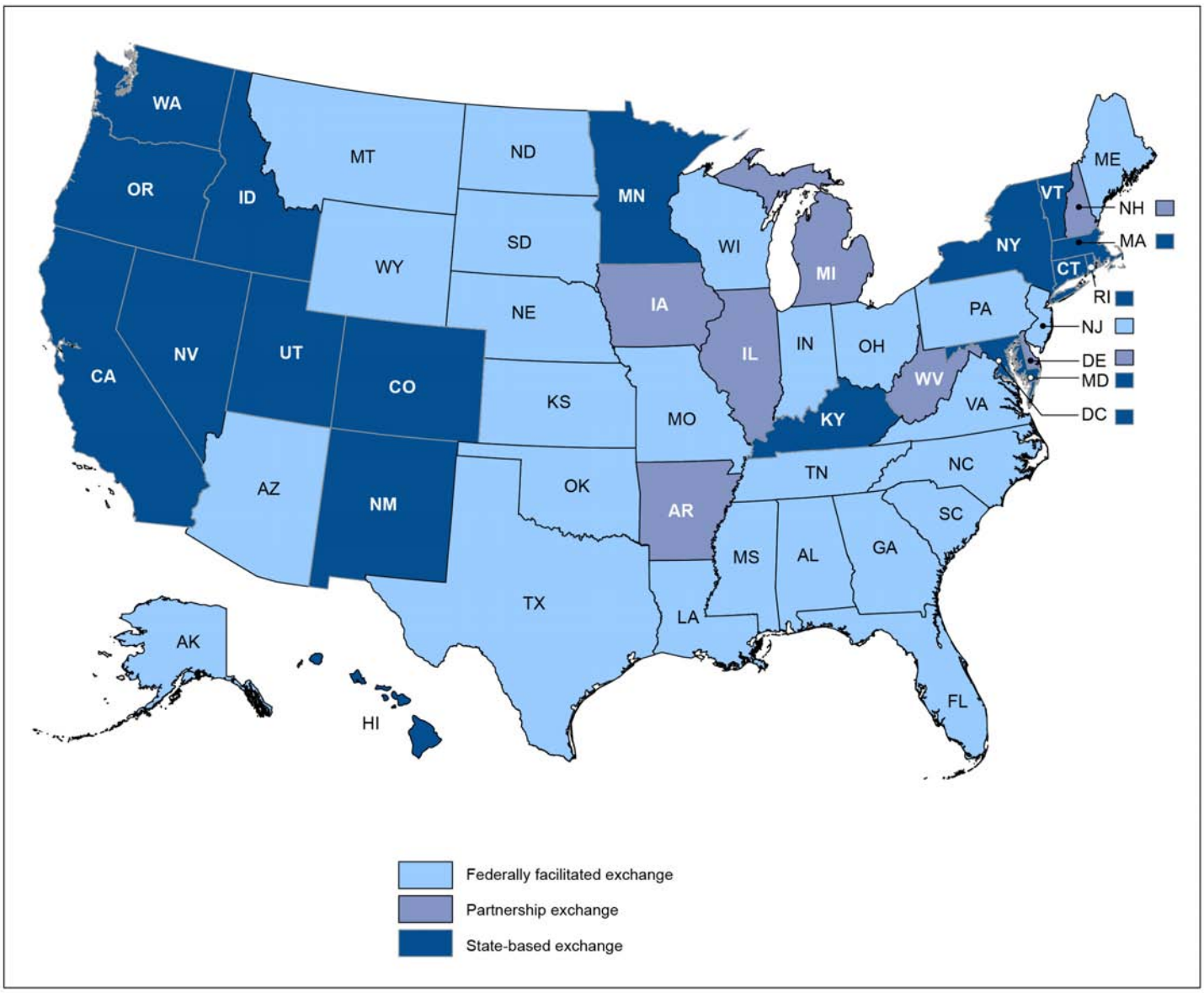
[11]PPACA provides cost sharing subsidies to certain individuals to help them pay for costs related to the use of health services. Cost sharing generally refers to costs that an individual must pay when using services that are covered under the health plan that the person is enrolled in. Common forms of cost sharing include copayments and deductibles.

[12]The Basic Health Program (BHP) is an alternative to qualified health plans under which states may offer subsidized coverage to non-elderly individuals with incomes between 133 and 200 percent of the federal poverty level who are otherwise not eligible for other types of coverage such as affordable employer-sponsored insurance or traditional Medicaid. For operating this program, states will receive federal funding equivalent to 95 percent of the premium tax credits and cost sharing reductions that would apply to individuals if they were enrolled in exchange plans.

[13]PPACA requires states to establish exchanges by January 1, 2014. Pub. L. No. 111-148, § 1311(b), 124 Stat. 173. The Secretary of HHS must establish and operate an exchange in states that do not elect to operate an exchange or in states where the Secretary determines, by January 1, 2013, that a state has failed to take actions necessary to establish an exchange. Pub. L. No. 111-148, § 1321(c), 124 Stat. 186. Through subsequent guidance, HHS has identified options for states to partner with HHS when HHS establishes and operates an exchange. Specifically, under this model, states may assist HHS in carrying out certain functions of the exchanges.

could choose, referred to as a partnership exchange. According to HHS, a partnership exchange is a variation of a federally facilitated exchange, whereby HHS establishes and generally operates the exchange and the state assists HHS with operating various functions of the exchange. States opting for a partnership exchange were required to submit an application blueprint to HHS by February 15, 2013, detailing how the state planned to implement various functions and activities. According to HHS, as of March 14, 2013, 18 states have opted to establish a state-based exchange. In another 7 states, HHS will establish and operate a partnership exchange, with states assisting in certain functions (see figure 1). HHS's approval of these exchanges is conditional on the states' addressing a list of activities highlighted in the state's application blueprint. HHS will establish a federally facilitated exchange in the remaining 26 states.

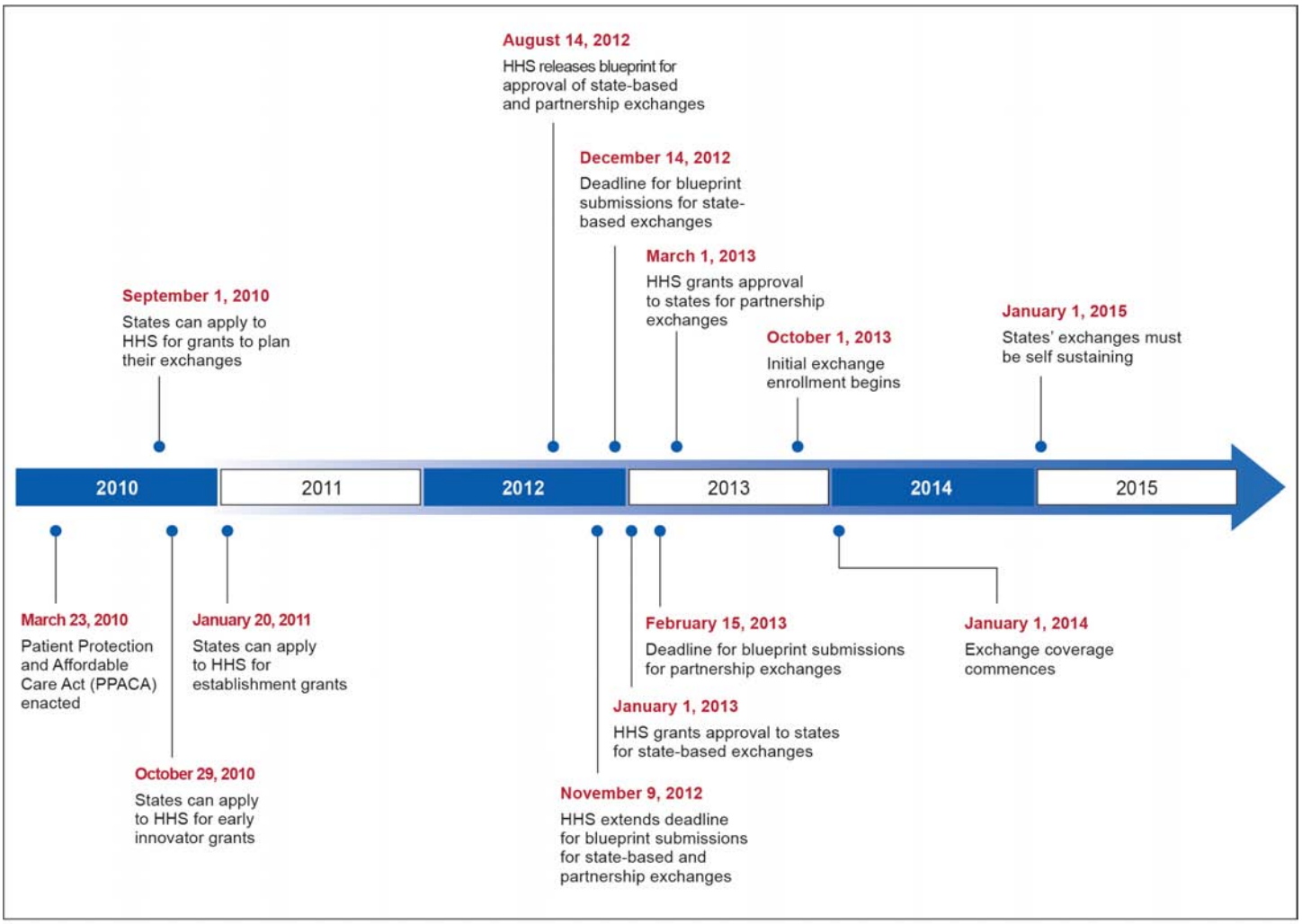
Figure 1: Distribution of State Decisions on Exchange Type, as of March 14, 2013



Sources: GAO analysis of CMS data; Map Resources (map).

Regardless of the type of exchange states plan to establish, open enrollment in the exchange is to begin on October 1, 2013. See figure 2 for a timeline of key milestones under PPACA.

Figure 2: Timeline for Key Exchange Milestones



Source: GAO analysis of relevant PPACA provisions and HHS regulations and guidance.

To help states establish an exchange, federal grants are available for planning and implementation activities, as well as for the first year of an exchange's operation. As shown in figure 2, beginning in September 2010, states could apply for up to $1 million in planning grants to conduct

initial research and exchange planning activities.[14] Establishment grants became available to eligible states to set up their own exchanges or to support activities related to the establishment of partnership exchanges or federally facilitated exchanges in the state.[15] States could also apply for "early innovator" grants to help them develop and adapt technology systems to determine eligibility and enrollment. These grants were awarded in 2011 to states that demonstrated an ability to develop IT systems on a fast track schedule and a willingness to share design and implementation solutions with other states. Between September 2010 and March 2013, HHS awarded exchange grants totaling nearly $3.7 billion to 50 states.[16,17] Of that amount, states returned over $98 million in grant awards.[18] HHS awarded over $1 billion dollars to the 7 states in our review—New York and Oregon were awarded the largest amounts. Figure 3 shows the range of exchange grant funding by state as of March 27, 2013.

[14]These grants were awarded to states in 2010 and 2011, and are no longer being awarded. These grants provided one year of funding and a state could receive only one grant.

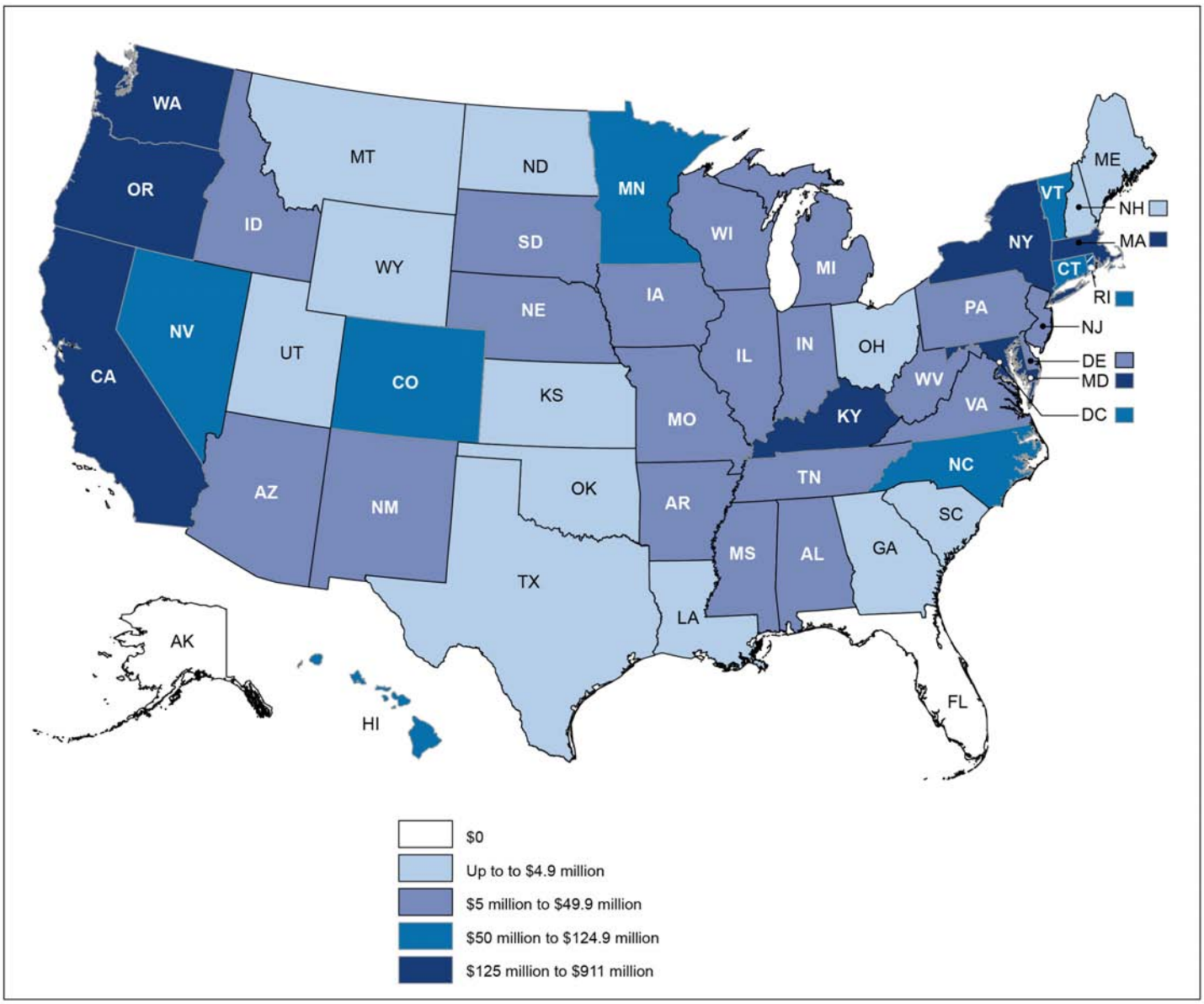
[15]There are two types of establishment grants. Level I establishment grants, awarded to states in 2010, were available to all states, whether they were developing a state-based exchange or participating in a partnership exchange or a federally facilitated exchange. These grants provided for one year of funding, and a state could apply for multiple grants. Level II establishment grants, awarded on a quarterly basis through 2015, are available only to states that create a state-based exchange and are moving ahead at a faster pace.

[16] As noted earlier, for purposes of this report, we refer to the District of Columbia as a state.

[17]One state, Alaska, did not apply for and was not awarded exchange grant funding.

[18]As of March 27, 2013, certain states had returned this funding to HHS for reasons such as the state's decision not to pursue a state-based exchange.

Figure 3: Range of exchange grant funding by state, as of March 27, 2013[a]



Sources: GAO analysis of CMS data; Map Resources (map).

[a]Grant funding reflects the total amounts awarded minus amounts that a state returned. As noted earlier, certain states have returned this funding to HHS for reasons such as a state's decision not to pursue a state-based exchange.

States' Responsibilities for Establishing Exchanges Vary, Depending on the Type of Exchange

PPACA and HHS implementing regulations and guidance require states and exchanges to carry out a number of key functions, for which state responsibilities vary by exchange type. A state that chooses to run its own exchange is responsible for: establishing an operating and governance structure, ensuring QHPs are certified and available to qualified individuals,[19] streamlining eligibility and enrollment systems, conducting consumer outreach and assistance, and ensuring the financial sustainability of the exchange. A state that has created a partnership exchange may assist HHS in some of these functions, such as making QHP certification recommendations and conducting aspects of consumer outreach and assistance.

States Must Establish an Operating and Governance Structure

A state choosing to operate a state-based exchange must establish the operating and governance structure through which the exchange will be run and managed. Specifically, the state must determine whether the exchange will be run as a governmental agency or a nonprofit organization. Regardless of whether the exchange will be run as a governmental agency or a nonprofit, the state has the authority to allow an exchange to contract with other entities to carry out one or more responsibilities of the exchange.[20]

Further, a state operating an exchange as an independent state agency or nonprofit entity established by the state must establish a governance board that meets certain requirements. For example, the board must be administered under a publicly adopted operating charter or by-laws, ensure the board's membership includes at least one voting member who is a consumer representative and is not made up of a majority of voting representatives with conflicts of interest (for example, representatives of health insurance issuers), and ensure that a majority of the voting members have relevant health care experience (for example, health benefits administration or public health).

[19]Qualified individuals must reside in the state in which the exchange is offered and include U.S. citizens and legal immigrants who are not incarcerated.

[20]A state exchange may contract with an eligible entity, including a state Medicaid agency or any other state agency, incorporated under and subject to the laws of at least one state, that has demonstrated experience on a state or regional basis in the individual and small group health insurance markets and in benefits coverage, but is not an issuer.

States Must Ensure Exchanges Will be Capable of Certifying Qualified Health Plans

States choosing to operate their own exchange must ensure the exchange will be capable of certifying qualified health plans (QHP) and making them available to qualified individuals. A state opting for a partnership exchange may choose to engage in this function. In a partnership exchange, health insurance issuers will work directly with the state to submit all QHP issuer application information in accordance with state guidance.[21] An exchange may only offer health plans that are certified as a QHP. To be certified, a health plan must meet two categories of requirements: (1) the health insurance issuer must be in compliance with minimum certification requirements as defined by HHS; and (2) the availability of the health plan through an exchange must be in the interest of qualified individuals and employers. To meet the minimum certification requirements, health insurance issuers must, for example, (1) be licensed and in good standing in each state in which the insurance coverage is offered,[22] (2) comply with quality improvement standards, and (3) ensure their plan networks are adequate and include essential community health providers, where available, to provide timely access to services for predominantly low-income, medically underserved individuals.

How an exchange determines whether a plan is in the interest of qualified individuals and employers may depend on how the state organizes its market. The state may choose to organize its market as an "active purchaser" or as a "passive purchaser." As an active purchaser, the state will decide which health plans can be offered in the exchange on the basis of such factors as select criteria, quality, and price. As a passive purchaser, the state may permit all QHPs to participate in the exchange.

[21]CMS will work with states participating in state partnership exchanges to ensure that such guidance is consistent with federal regulatory standards and operational timelines. CMS anticipates that states will choose to use the National Association of Insurance Commissioners' System for Electronic Rate and Form Filing to collect and review QHP data. The state will review issuer applications for QHP certification for compliance with the standards and will provide a certification recommendation for each QHP to CMS. CMS will review and confirm the state's recommendations, coordinate plan preview, make final certification decisions, and make available certified QHP plans in the exchange for the relevant state partnership exchange. CMS will work closely with states in state partnership exchanges to coordinate this process.

[22] "Good standing" generally means that the insurer has no outstanding sanctions imposed by a state's department of insurance.

In order to be certified as a QHP, plans will also need to meet certain coverage requirements. Specifically, PPACA requires that QHPs provide essential health benefits (EHB) which include coverage within 10 categories:

1. Ambulatory patient services,
2. Emergency services,
3. Hospitalization,
4. Maternity and newborn care,
5. Mental health benefits and substance abuse disorder services, including behavioral health treatment,
6. Prescription drugs,
7. Rehabilitative and habilitative services and devices,
8. Laboratory services,
9. Preventive and wellness services and chronic disease management, and
10. Pediatric services including oral and vision care.[23]

In addition, within an exchange, health insurance issuers may offer QHPs at one of four levels of coverage that reflect out-of-pocket expenses for an enrollee. The four levels of coverage correspond to a percentage paid by a health plan of the total allowed costs of benefit designated by metal tiers: 60 percent (bronze), 70 percent (silver), 80 percent (gold), and 90 percent (platinum).[24] At a minimum, however, a health insurance issuer must offer QHPs at both the silver and gold levels of coverage.

[23]Under PPACA, states may require plans to offer benefits in addition to these categories. States are required to either make payments to individual enrollees or to the issuers to defray the costs of these additional benefits.

[24]Pub. L. No. 111-148, §§ 1302 (d), 10104(b)(1), 124 Stat. 167, 896. Accordingly, the actuarial value of a plan represents the expected percentage of costs the plan will incur for the EHB services provided to a standard population. For example, a gold plan with an 80 percent actuarial value would be expected to pay, on average, 80 percent of a standard population's expected medical expenses for the EHB. The individuals covered by the plan would be expected to pay, on average, the remaining 20 percent of the expected cost-sharing expenses in the form of deductibles, copayments, and coinsurance.

States may choose to identify a benchmark plan for their state that, at a minimum, covers the EHB. According to HHS, the benchmark plan reflects the scope of services and limits offered by a "typical employer" plan in the state.[25] HHS identified four plans that a state could choose: (1) one of the three largest plans in the state's small group market health insurance plans; (2) one of the three largest state employee health benefit plans; (3) one of the three largest national plans offered through the Federal Employees Health Benefits Program; or (4) the largest commercial non-Medicaid health maintenance organization operating in the state. If the state does not select a benchmark plan, the state will default to the largest plan by enrollment in the largest product by enrollment in the state's small group market.[26]

States also have the option of requiring QHPs to offer benefits in addition to EHB. If they choose to do so, states must identify which specific state-required benefits are in excess of the EHB. Under HHS regulations, if a state required QHPs to cover benefits beyond EHB on or after January 1, 2012, the state would be responsible for defraying the cost of these services.

[25] Each state's benchmark plan will apply to their respective exchanges for plan years 2014 and 2015, while HHS will revisit this issue for the 2016 plan year.

[26] The term "small group market health plan" is defined as the health insurance market in which employers with 100 or fewer employees offer group health plans.

States Must Streamline Eligibility and Enrollment Systems

States operating their own exchanges generally must ensure that the exchanges will be able to determine an applicant's eligibility for QHPs, as well as for Medicaid and CHIP.[27] Specifically, under PPACA and implementing regulations, states must establish an electronic, streamlined, and coordinated system through which an individual may apply for and receive a determination of eligibility for enrollment in a QHP,[28] Medicaid, CHIP, or Basic Health Program, if applicable. Exchanges must be able to use a single application that can be completed online, by mail, over the telephone, or in person. This means that no matter how an individual submits an application or which program receives the application, an individual will use the same application and receive an eligibility determination, without the need to submit information to multiple programs. Thus, state IT systems must be interoperable and integrated with an exchange, Medicaid, and CHIP to allow consumers to easily switch from private insurance to Medicaid and CHIP as their circumstances change. Exchanges must also be able to transmit certain data to HHS to be verified before determining applicants' eligibility. HHS, through a "federal data services hub," will coordinate with the Department of Homeland Security, the Internal Revenue Service, and other federal agencies to verify applicant information, such as citizenship and household income. With the amount of data that states must share with HHS in order to verify eligibility, developing streamlined eligibility and

[27] States with either state-based exchanges or partnership exchanges have the option of (1) allowing exchanges to make eligibility determinations for Medicaid and CHIP or (2) having exchanges make an assessment, with the state Medicaid agency or other relevant state agency making the actual determinations of eligibility. In addition, PPACA and implementing regulations provide for states, regardless of whether they are establishing an exchange, to create a transitional reinsurance program for 2014 through 2016 to help stabilize premiums for coverage in the individual market. HHS will establish a reinsurance program for any state that fails to establish this program. Further, beginning with the 2014 benefit year, each state electing to operate an exchange may establish a permanent risk adjustment program for all non-grandfathered plans in the individual and small group market both inside and outside of the exchanges. HHS will establish this risk adjustment program for any state that will not operate an exchange or for states operating an exchange but which do not elect to administer the risk adjustment program. These risk-spreading mechanisms are designed to mitigate the potential impact of adverse selection and provide stability for health insurance issuers in the individual and small group markets. We did not include states' reinsurance and risk adjustment activities in the scope of our work.

[28] In determining eligibility for a QHP, exchanges must also determine whether applicants qualify for premium tax credits or cost sharing reductions for these plans. States electing to establish and operate state-based exchanges, however, may choose to rely on HHS to make these determinations.

enrollment systems is a vast undertaking requiring states to develop sophisticated IT systems.

As part of the enrollment and eligibility process, HHS directs exchanges to rely on existing electronic sources of data to the maximum extent possible to verify relevant information, with high levels of privacy and security protection for consumers. For the majority of applicants, an automated electronic data matching process should eliminate the need for paper documentation.

States Must Conduct Consumer Assistance and Outreach

States that operate their own exchange are required to conduct consumer assistance and outreach through a number of activities. States that partner with HHS may assume some aspects of this function. Specifically, exchanges must have consumer assistance functions that are available to consumers to provide help in using the exchange. Such functions are required to be accessible to individuals with disabilities and individuals with limited English proficiency. Exchanges are also required to operate a toll-free call center and maintain a website that, among other things, allows consumers to compare qualified health plan benefits, costs, and quality ratings, and select and enroll in a plan. Further, exchanges must assist consumers with accessing and obtaining coverage, including providing tools to help consumers access the exchange, determine which plan or program to enroll in, and determine their eligibility for premium tax credits and cost sharing reductions.

As part of states' consumer outreach and assistance activities, each exchange is also required to operate a navigator program, which will provide eligible organizations with grants so they can raise awareness of QHPs' availability and facilitate consumers' selection of QHPs. Navigators may include organizations such as trade associations, community and consumer-focused non-profit groups and chambers of commerce. Navigators must maintain expertise in eligibility, enrollment, and program specifications. The entity serving as a navigator must deliver information to the public in a fair, accurate, and impartial manner that is culturally and linguistically appropriate to the needs of the population they serve.[29] HHS

[29] Unlike insurance agents and brokers, navigators are not authorized to receive compensation or other forms of payment—either directly or indirectly—from any health insurance issuer in connection with the enrollment of any qualified individuals, or employees of a qualified employer, in a QHP.

afforded state-based exchanges the opportunity to use in-person assisters in certain circumstances to ensure that the full range of services that the navigator program will provide in subsequent years are provided during the exchanges' initial year of operation. State partnership exchanges in which states will assist with consumer assistance functions will be required to establish and operate an in-person assistance program. While in-person assisters may receive the same training as navigators, they are part of a separate and distinct program and can use establishment grants to fund their operation.

PPACA requires that exchanges regularly consult with certain groups of stakeholders for all activities, including establishing and operating consumer assistance programs. These stakeholders include educated health care consumers enrolled in QHPs, representatives of small businesses and self-employed individuals, advocates for enrolling hard-to-reach populations, and individuals and entities with experience in facilitating enrollment in health insurance coverage. Further, HHS provided supplementing guidance on activities states may want to consider as part of their outreach and education, including:[30]

- performing market analysis or an environmental scan to assess outreach and education needs to determine geographic and demographic-based target areas and vulnerable populations for outreach efforts;
- developing a "toolkit" for outreach to include educational materials and information;
- designing a media strategy and other information dissemination tools; and
- submitting a final outreach and education plan to HHS.

States Must Ensure Financial Sustainability of the Exchange

States operating their own exchanges are required to ensure their exchanges will be self-sustaining by 2015—meaning that states must ensure their exchanges have sufficient funding to support ongoing operations.[31] PPACA allows these exchanges to generate funding for

[30] HHS, *Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges*, January 20, 2011.

[31] PPACA prohibits the awarding of establishment grants for exchanges after January 1, 2015. HHS has clarified, however, that states seeking federal funding to establish exchanges may be awarded such funds until December 31, 2014.

exchange operations in certain ways, such as charging user fees or other assessment fees to exchange-participating health insurance issuers. Under HHS guidance, states are to submit a plan to HHS to demonstrate how their exchanges will be financially sustainable by January 1, 2015.

Despite Some Challenges, Selected States Have Taken Action to Establish Exchanges and Report They Will Be Ready for Enrollment by October 2013

Nearly All Selected States Have Created an Operating and Governance Structure

Six of the seven states in our study were conditionally approved by HHS to create a state-based exchange. State exchange officials we interviewed said that, among the reasons that states chose to establish this type of exchange are that it allows the state to (1) maintain consistency between the insurance market inside and outside the exchange, (2) better control its insurance market, and (3) have opportunities to better meet the unique needs of the state's population. In contrast, Iowa officials said the state opted to partner with HHS due to the high cost of building and maintaining a state-based exchange—which the state estimated to be $15.9 million annually. Iowa officials also reported that, by assuming responsibility over certain exchange activities, such as overseeing and certifying qualified health plans, partnering with HHS allows the state to maintain regulatory control over its insurance market. Iowa officials told us that the state plans to transition to a state-based exchange sometime in the future.

To begin building an exchange, six of the seven states have established an operating structure through state legislation or by executive order. As a partnership state, Iowa is not establishing an operating structure at this time because HHS will initially establish and operate the exchange. As Iowa switches to a state-based exchange, it will need to establish an operating structure.

As shown in table 1, states varied in how they established their exchange operating structures. For example, three states—New York, Nevada, and Rhode Island—plan to run their exchange as entities within an existing state agency. Exchange officials in New York told us that basing the exchange within an existing state agency—New York's Department of Health—allows the state to leverage established administrative systems and procedures, thereby relieving the exchange from some of the administrative burdens common to start-up organizations. Table 1 also shows that five out of the six states that have established an exchange have also created a governance board that ranges in member composition and expertise. Consistent with HHS regulation, all five governance boards include members that represent consumer interests.

Table 1: Summary of Exchange Operating and Governance Structures in Selected States

State	Type of exchange	Operating structure	Governance structure
District of Columbia	State-based	Independent authority established by state legislation	11 Board members: 4 non-voting ex officio members (or their designees) and 7 voting members appointed by the mayor with the consent of the council with demonstrated expertise in at least 2 of 12 designated areas, such as health care financing and public health programs; at least 1 member must possess knowledge of health care consumer interest advocacy. An executive director, hired by the board, will direct, administer, and manage the operations of the authority.
Iowa	Partnership	Will defer to HHS	Will defer to HHS
Minnesota	State-based	Board established by state legislation[a]	7 Board members: the commissioner of Human Services (or a designee) and 6 members appointed by the governor with the consent of both the state Senate and the House of Representatives—1 member representing interests of individual consumers eligible for individual market coverage, 1 member representing individual consumers eligible for public health care program coverage, 1 member representing small employers, 1 member with expertise in health administration and health care finance, 1 member with expertise in public health and the uninsured, and 1 member representing health policy issues related to small group and individual markets.
Nevada	State-based	Independent public agency established by state legislation	10 Board members: 3 ex officio non-voting members (or their designees) and 7 voting members—5 appointed by the governor, 1 member appointed by the Senate majority leader and 1 member appointed by the speaker of Assembly. The Board has 5 advisory committees: (1) Finance and Sustainability; (2) Plan Certification and Management; (3) Small Business Health Options Program Exchange; (4) Reinsurance and Risk Adjustment; and (5) Consumer Assistance.

State	Type of exchange	Operating structure	Governance structure
New York	State-based	Division within the New York State Department of Health established by executive order	No board created. The New York Health Benefit Exchange established five regional advisory committees to advise and make recommendations on the exchange establishment and operations. Committee members include consumer advocates, small business representatives, health care providers, health plans, agents, brokers, insurers, labor organizations, and policy experts.
Oregon	State-based	Public corporation established by legislation[b]	9 Board members: 2 ex officio voting members (or their designees) and 7 voting members appointed by the governor with Senate confirmation.[c] At least 2 voting members must be: (1) an individual consumer purchasing health care through the exchange; and (2) a small business employer purchasing health care through the exchange.
Rhode Island	State-based	Department within executive department established by executive order	13 Board members, including the director of the Department of Administration; the Health Insurance Commissioner; the Secretary of the executive office of Health and Human Services; the director of the Department of Health; and 9 members appointed by the governor: 2 represent consumer organizations, 2 represent small businesses.[d] A director of the Division of the Rhode Island Health Benefits Exchange—appointed by the governor—will organize, administer, and manage the operations of the division. No member of the Board is affiliated with a group or organization that has a conflict of interest with the exchange.

Source: GAO analysis of state legislation and executive orders.

[a]Under Minnesota law, an agency in the executive branch who is authorized to (1) perform administrative acts, (2) issue or revoke licenses or certifications, (3) make rules, or (4) adjudicate contested cases or appeals must be designated as a "board." The Minnesota Insurance Marketplace was established with such authorities.

[b]The Oregon Health Insurance Exchange Corporation is a public corporation performing governmental functions and exercising governmental powers. O.R.S. § 741.001 (2011).

[c]The voting members must collectively offer expertise, knowledge, and experience in individual insurance purchasing, business, finance, sales, health benefits administration, individual and small group health insurance and use of the health insurance exchange.

[d]The board must include a balance of members with expertise in a diverse range of health care areas including, but not limited to, health benefits plan administration, health care finance and accounting, administering a public or private health care delivery system, state employee health purchasing, electronic commerce, and promoting health and wellness.

States Have Taken Steps toward Certifying Qualified Health Plans

All seven states in our review reported taking steps toward certifying QHPs. Two states have decided whether their exchanges will have the authority to actively select which QHPs may participate in the exchange. As active purchasers, exchanges can select QHPs by applying additional criteria and negotiating with health insurance issuers, or by a combination of these actions. As table 2 shows, two states decided to organize their exchanges as active purchasers, while the remaining five states will organize their exchanges as passive purchasers, allowing all plans that meet the minimum requirements for QHPs to participate in the exchange.

To identify benchmark plans, all selected states analyzed the plans and considered various factors, including whether the plans offered by the state required benefits in addition to the EHB required under PPACA. In choosing their benchmark plans, all seven states identified plans that included state-mandated benefits that did not exceed PPACA's EHB requirements. Table 2 shows that five of the seven states recommended benchmark plans to HHS, while two states chose not to identify a benchmark plan and will default to the largest small group plan in their state.

Table 2: Selected States' Insurance Market Organization and Essential Health Benefits (EHB)

State	Market organization	Essential health benefits benchmark plan	Plan type
District of Columbia	passive purchaser	recommended	small group
Iowa	passive purchaser	defaulted	small group
Minnesota	passive purchaser[a]	defaulted	small group
Nevada	passive purchaser	recommended	small group
New York	passive purchaser	recommended	small group
Oregon	active purchaser	recommended	small group
Rhode Island	active purchaser	recommended	small group

Source: GAO analysis of HHS documents and the Henry Kaiser Family Foundation as of January 3, 2013 and March 13, 2013.

[a]According to Minnesota officials, the state expects to organize its market as an active purchaser in 2015.

Definitions: "Recommended" means that a state has recommended an EHB benchmark plan to HHS or developed a preliminary EHB recommendation. "Defaulted" means that a state has not recommended an EHB benchmark plan and will default to the largest small group plan.

All seven states included in our review have taken steps to invite health insurers to participate in their exchanges. For example, in January 2013, New York released an invitation to participate and began accepting applications for licensed insurers in the state (and those expected to be licensed by October 2013) to apply for certain QHPs to be offered through the New York exchange. The exchange governing board will review the applications of individual health plans to make sure they meet all federal minimum participation standards and other requirements to be certified as QHPs. Officials reported that the exchange anticipates certifying plans by mid-July 2013, and will be ready for enrollment on October 1, 2013.

Minnesota and Oregon requested applications in October 2012 from insurers who wanted to offer QHPs in the state's exchange, while the District began accepting applications in April 2013. Insurers certified

through the exchange must demonstrate the ability to meet minimum certification requirements including providing adequate networks, care coordination, and quality measures, among other things. Oregon officials told us the state plans to certify QHPs by the summer of 2013 and begin enrolling consumers in October 2013.

States Encountered Time Constraints and Other Challenges, but Are Moving Forward in Simplifying and Streamlining Eligibility and Enrollment Systems

All seven states in our review are in various stages of developing an IT infrastructure that can support a streamlined and integrated eligibility and enrollment system. A major focus of the states' integration activities is redesigning their current Medicaid and CHIP eligibility and enrollment systems. State officials described this as the most significant and onerous aspect of developing an IT infrastructure to support the exchange, given the age and limited functionality of current state systems. All seven states in our review use outdated systems, which lack the capacity to support web-based streamlined processes.

Further, the majority of states operate multiple eligibility and enrollment systems that serve individuals enrolled not only in Medicaid and CHIP but in other public assistance programs, such as Temporary Assistance to Needy Families (TANF) and the Supplemental Nutrition Assistance Program (SNAP). These separate systems, which may be managed by multiple entities across the state, have limited interface capabilities. For example, similar to other states in our review, Oregon operates multiple enrollment and eligibility systems, whereby only a limited amount of enrollee information is accessible and reusable across multiple programs. In addition, Oregon has multiple interfaces between these programs to support integrated business processes, making systems complex, inflexible, and expensive to maintain. To address these kinds of issues, states are using enhanced federal funding, referred to as the 90 percent match, to either upgrade or rebuild their outdated Medicaid and CHIP eligibility and enrollment systems to meet the requirements under

PPACA.[32] As states upgrade their Medicaid and CHIP systems, many are also taking the opportunity to integrate enrollment and eligibility processes for other public assistance programs, such as TANF and SNAP, in order to provide shared services across programs.

In addition to upgrading eligibility and enrollment systems, six of the seven states are in various stages of building the exchange IT infrastructure needed to integrate these systems and allow consumers to navigate among health programs and purchase QHPs through a variety of access points, using a single streamlined application.[33] The integrated systems will enable states to collect information needed for eligibility determination and verification, not only from their own state systems, but from federal systems as well. These systems are to utilize a federal data services hub provided by CMS, which will serve as a single source of the federal data that are needed to determine eligibility. To use this system, state systems are to transmit requests for data through the federal data services hub to multiple federal agencies, such as the Department of Homeland Security and the Internal Revenue Service.[34] The federal data services hub is to return the data in near real-time back to the state systems where it can be used to verify the information the states collected for determining applicants' eligibility.

Two states—New York and Oregon—are further along in this work than the other states in our review, as they were awarded early innovator grants to develop an IT infrastructure that will integrate Medicaid, CHIP, and other programs. To develop its state integrated systems, Oregon will use a commercial framework that can be easily adopted and used by

[32]States may receive an enhanced administrative federal match—90 percent—for the design, development, and installation or enhancement of eligibility determination systems until December 31, 2015. In order to qualify for the 90 percent match, states must submit an advanced planning document to CMS for review and approval. As part of its review, CMS must determine that the design, development, installation, or enhancement of a state's eligibility system meets a number of standards and conditions, including seamless coordination with the health insurance exchanges. The 90 percent match is available only for costs incurred after April 19, 2011, and before December 31, 2015. Beginning April 19, 2011, states may also qualify for a 75 percent match for the operation of eligibility systems that continue to meet applicable standards and conditions. This enhanced match is not available for systems that do not meet these requirements by December 31, 2015.

[33] As a partnership state, Iowa is not required to establish an exchange infrastructure.

[34]Other federal agencies include the Social Security Administration, the Veteran's Heath Administration, Tricare, the Peace Corps, the Office of Personnel Management, and CMS.

other states. As part of its approach and consistent with the intent of the early innovator grant, Oregon has begun working with multiple states to share this framework, including their analyses, design, and other components.

CCIIO officials indicated that readiness testing of states' eligibility and enrollment systems for the exchange will begin in March 2013 and continue through August 2013. To date, three of the states in our review—Nevada, New York and Oregon—have begun testing various aspects of their eligibility, enrollment, and federal data services hub functionality with CCIIO. According to CCIIO officials, the remaining states in our review are expected to begin testing over the next few months. Most state officials told us that because of the complexities of developing an integrated and streamlined eligibility and enrollment system, they plan to use a phased approach to implementation to ensure that key system changes are in place before 2014. Specifically, they will focus first on ensuring that new systems are capable of determining eligibility for enrollment in QHPs, Medicaid, CHIP, and the exchange, and will integrate other assistance programs—such as SNAP and TANF—during later stages.

While state officials reported they expect to be ready to enroll individuals by October 1, 2013 and are moving forward with IT-related efforts, officials in six states identified challenges they faced with developing aspects of their systems, given compressed timeframes and a lack of clear federal requirements related to the federal data services hub. For example, exchange officials expressed concerns about the timeframes for implementation, because of the complexities and large undertaking of integrating and modernizing these systems. Further, most officials reported that transitioning multiple programs into a streamlined and coordinated eligibility and enrollment system could take years to fully implement. Officials in six states told us that developing business rules for the eligibility and enrollment system was challenging because they did not have complete information on the requirements of the federal data services hub. Because of implementation timelines, however, these officials said they needed to begin IT-related activities before receiving complete federal guidance. Most officials reported they were concerned that this could lead to changes late in the development process. To address this uncertainty, a few states built in flexibility in their requests for proposals when making procurement decisions. Officials in one state also reported that, in order to meet timeframes, modifications to the IT systems will be completed in 2014 (after enrollment begins), based on guidance issued late in the development process. CMS has indicated that

while the federal data services hub is still under development, CMS has released guidance to the states on how to access or verify data through the federal data services hub through such sources as webinars, conferences, and other forums. Despite the challenges associated with developing the IT systems, officials in six states reported their systems will be ready for enrollment by October 1, 2013.

States are Developing Outreach and Assistance Programs to Help Consumers Enroll in the Exchange

Six of the seven states included in our review are in various stages of developing a consumer outreach and assistance program to reach out to potential consumers and help them enroll. As a partnership state, Iowa has not yet decided whether and to what extent it will assist HHS with aspects of this function. Most states have contracted with or plan to contract with vendors to design a program. The vendors will assist with the exchanges' branding, which will be able to translate materials into multiple languages and take into account the needs of individuals with disabilities. The vendors will also design and implement communications and marketing plans (for example, radio and television ads) with the goal of enrolling the maximum number of eligible individuals into the exchange.

As part of the consumer outreach and assistance programs, states will use a range of tools to provide potential consumers with information and assist them in enrolling in an exchange. These include:

Navigators and in-person assistors. Six of the seven states in our review plan to use navigators and assistors to provide in-person enrollment assistance to individuals applying for health insurance, such as assisting individuals with selecting QHPs or providing information to individuals in a way that is culturally and linguistically appropriate. HHS plans to assume responsibility for operating the navigator program in Iowa, since it is a partnership state. Nearly all states told us that assistance will need to be tailored to the unique needs of their populations. For example, Nevada officials told us that their program must be able to accommodate individuals who live in Nevada's remote frontier region, where population density can be as low as two people per square mile and which may lack infrastructure such as Internet access. New York officials told us they will address linguistic and cultural challenges reaching individuals in some of New York City's more diverse communities.

Four states—the District, New York, Oregon, and Rhode Island—plan to leverage state resources within existing health and human services

programs to support navigators and assistors. For example, Oregon plans to model its navigator program after a state Medicaid program that provides uninsured individuals with premium assistance and access to health care information and resources. Similarly, New York, which issued a request for application in February 2013 for in-person assistors and navigators, will model its approach after its community assistance programs and will provide assistance through a variety of access points in other local areas across the state. New York officials told us that the state plans to sign contracts with navigators and in-person assistors in the summer of 2013 and begin training them in August or September 2013.

Web portals and call centers. Six of the seven states in our review are designing web portals and contact centers as part of their consumer assistance and outreach initiatives. The seventh state, Iowa, is a partnership state and is deferring this responsibility to HHS. State planning documents in the remaining six states indicated that the web portals and the contact centers will be central to assisting residents. State officials told us that web portals, in particular, will ease comparisons among health plans by providing standardized information about each health plan's premium, benefit structure, and cost-sharing provisions. For example, District officials told us that a web portal, which is being developed in conjunction with the IT infrastructure, will be the key access point for consumers to interface with the exchange. Similarly, Minnesota is designing a contact center that will offer multiple modes of assistance through such means as Internet access, telephone, mail, and in-person assistance. State officials told us they expect the customer service functions will be ready to operate on October 1, 2013.

States Are Planning for Long-Term Sustainability with Multiple Revenue Options, but Faced Uncertainties Estimating Costs

Officials in six states in our review reported they are considering a number of revenue options for financially sustaining their exchange.[35] For example, as part of the planning efforts to develop these options, three states—Nevada, Minnesota, and the District—created work groups to recommend options for achieving long-term sustainability. In particular, both Minnesota and Nevada created working groups intended to review and propose financing options to enable the exchange to be self-sustaining by January 1, 2015.

[35] As a partnership exchange, Iowa is not responsible for carrying out this key function.

While states reported they are considering options to fund ongoing exchange costs, such as salaries and benefits, consulting services, outreach and marketing, and information technology, three states will charge fees to insurance carriers participating in the exchange. Specifically:

- Oregon will charge an administrative fee to insurance carriers participating in the exchange. In particular, carriers will be required to pay a percentage of the premiums (up to 5 percent) based on the number of enrollees in the exchange. The fee is designed to decrease as enrollment in the exchange increases. For example, if more than 300,000 individuals enroll in the exchange, the state exchange will charge carriers up to a 3 percent fee. If enrollment is at or below 175,000, the state exchange will charge carriers up to a 5 percent fee. Between 100,000 and 120,000 enrollees would be required for the exchange to be self-sustaining using the maximum administrative fee of 5 percent. Further, any excess revenues generated above the cost of operating the exchange may be placed in a reserve fund of up to 6 months of operating expenses or returned to insurance carriers.

- Nevada plans to charge insurance carriers a per member per month fee based on enrollment. In its financial sustainability plan, the state estimated the fee will amount to between $7.13 and $7.78 per member per month, which the state anticipates insurance carriers will build into their QHP premiums. In addition, based on the state's estimates, the state expects the fee will be paid by the advance premium tax credit. Nevada is also considering other potential sources of supplementary revenue, such as fees charged for stand-alone vision and dental plans.

- Minnesota plans to charge an administrative fee to insurance carriers participating in the exchange. Specifically, insurers will be required to pay a percentage of the premiums (about 3.5 percent) sold through the exchange. The fee will be based on the volume of insurance premiums for plans sold through the exchange.

While the states in our review have developed financing options, some state officials identified challenges with developing these options, given uncertainties related to exchange enrollment. Specifically, financial sustainability will be highly dependent on the size of enrollment and the take up rate, which is the percent of individuals that are estimated to enroll in coverage out of the entire eligible population. Some state officials reported that, estimating enrollment patterns without the benefit of

historical data from the exchange, could impact revenue projections. Further, according to one state, uptake estimates among various groups are "drastically different," so that estimating enrollment could result in significantly different per member per month carrier fees required to fund the exchange. Officials from two states reported that given these uncertainties, they expect to make adjustments to these estimates over time.

Agency Comments

We provided a draft of this report to the Secretary of HHS for review and comment. In response, HHS provided technical comments, which we incorporated as appropriate. Additionally, we provided excerpts of the draft report to exchange officials, such as the executive director and chief policy research and evaluation officer, in the seven states we interviewed for this study. We incorporated their technical comments as appropriate.

As arranged with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies of this report to the Secretary of HHS and interested congressional committees. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov. If you have any questions concerning this report, please contact Stanley J. Czerwinski at (202) 512-6806 or czerwinskis@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Key contributors to this report are listed in appendix II.

Sincerely yours,
Stanley J. Czerwinski
Director, Strategic Issues

Appendix I: Objectives, Scope & Methodology

This report addresses the following objectives: (1) identify states' responsibilities for establishing health benefit exchanges; and (2) describe the actions selected states have taken to establish exchanges and the challenges they have encountered.[1]

To identify states' responsibilities for establishing exchanges and the challenges they encountered, we reviewed selected Patient Protection and Affordable Care Act (PPACA) provisions and Department of Health and Human Services (HHS) implementing regulations and guidance related to the following categories:

- establishing a governance and operating structure;
- ensuring exchanges will be capable of certifying qualified health plans;
- simplifying and streamlining eligibility and enrollment systems;
- conducting consumer assistance and outreach; and
- ensuring the financial sustainability of the exchange.

Our review of HHS's guidance included HHS's blueprint for approval of state-based and partnership exchanges, information bulletins, questions and answers, and webinars. We also reviewed reports that have summarized state responsibilities with regard to the categories we included in our study, including those completed by federal agencies monitoring the implementation process and national associations that play a role in assisting states with implementation. Specifically, we reviewed reports from the Congressional Budget Office, the Congressional Research Service, and relevant state associations, such as the National Association of Insurance Commissioners, the National Conference of State Legislatures, the National Association of State Budget Officers, and the National Academy for State Health Policy.

To identify actions selected states have taken to create exchanges and the challenges they encountered, we conducted semistructured interviews with officials in seven states: the District of Columbia,[2] Iowa,

[1] For purposes of this report, we focus on certain categories of responsibilities. Therefore, this list does not include all states' responsibilities related to establishing an exchange.

[2] For ease of reporting and for purposes of this review, we refer to the District of Columbia as a state.

Minnesota, Nevada, New York, Oregon, and Rhode Island. We selected these states on the basis of:

1. The percentage of the uninsured population in states based on a 3-year average (2008 to 2010);
2. The percentage of the uninsured population in states in 2011;
3. The amount of exchange grants awarded to states on a per capita basis;[3]
4. Geographic dispersion; and
5. The type of exchange states intended to establish, based on data publicly available as of September 27, 2012.[4]

Table 3 shows the characteristics of the states selected for our review. We initially selected two states that intended to operate as federally facilitated exchanges—Florida and Maine. However, exchange officials in both states declined to be interviewed. Therefore, this review focused on states' responsibilities to establish state-based and partnership exchanges.

[3]We calculated the amount of total planning, establishment, and early innovator grants awarded on a per capita basis in each state as of September 27, 2012. We divided the total amount of grants awarded to states by the total state population.

[4]Specifically, we selected states on the basis of whether they intended to opt for a state-based, federally facilitated, or partnership exchange as of September 27, 2012. At that time, states had not yet formally declared their intention to HHS through the blueprint application. However, we used the most readily available information at that time from HHS and the Henry Kaiser Family Foundation.

Table 3: Characteristics of States Included in GAO Study

Selected States	Percentage of the uninsured population based on 3-year average	Percentage of the uninsured population in 2011	Exchange grants awarded on a per capita basis as of September 27, 2012	Census region	Status of intended state action, as of September 27, 2012
District of Columbia	11.4%	8.4%	$136.6	South	State-based
Iowa	10.7	10	11.6	Midwest	Studying options
Minnesota	8.7	9.2	13.9	Midwest	Studying options
Nevada	20	22.6	27.7	West	State-based
New York	14.2	12.2	9.5	Northeast	State-based
Oregon	16.5	13.8	16.9	West	State-based
Rhode Island	11.5	12	61.5	Northeast	State-based
Florida[a]	20.7	19.8	0	South	Federally facilitated
Maine[b]	9.9	10	0.8	Northeast	Federally facilitated

Source: GAO analysis of U.S. Census Bureau and HHS data.

[a] Florida was initially selected for inclusion in our review based on our selection criteria noted, but exchange officials declined to be interviewed for our study.

[b] Maine was initially selected for inclusion in our review based on our selection criteria noted, but exchange officials declined to be interviewed for our study.

We conducted initial interviews in person and by telephone between October and November 2012 and follow-up interviews between February and March 2013. The interview questions focused on states' actions regarding establishing an exchange and the challenges they encountered in the following areas: establishing an operating and governance structure, developing information technology systems and infrastructure to support a streamlined eligibility and enrollment system, ensuring exchanges will be capable of certifying qualified health plans, creating consumer outreach and assistance, and ensuring the exchange's financial sustainability. We also met with budget officials in some of the states to discuss the fiscal aspects of establishing exchanges, including how states will ensure exchanges are financially sustainable. The responses to the interviews are not intended to be representative of all state exchange and budget officials.

To supplement our interviews, we reviewed state planning, budget, and implementation documents, such as state blueprint applications, business plans, exchange grant applications, and contracting documents.

In addition, we conducted interviews with officials from the Centers for Medicare & Medicaid Services (CMS) and CMS's Center for Consumer

Information and Insurance Oversight and relevant state associations, including the National Association of State Budget Officers, National Conference of State Legislatures and the National Association of Insurance Commissioners.

We conducted our work from September 2011 to April 2013 in accordance with generally accepted government audit standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

Stanley J. Czerwinski, Director, Strategic Issues, (202) 512-6806 or czerwinskis@gao.gov

Staff Acknowledgments

In addition to the contact named above, Brenda Rabinowitz, Assistant Director; Kisha Clark, Analyst-in-Charge; Sandra Beattie, Amy Bowser, Robert Gebhart, Sherrice Kerns, Cynthia Saunders, Stacy Ann Spence, and Hemi Tewarson made key contributions to this report.