Reports and Research

Table of Contents

November 20, 2014 Board Meeting

ASPE
ISSUE BRIEF

HEALTH INSURANCE ISSUER PARTICIPATION AND NEW ENTRANTS IN THE HEALTH INSURANCE MARKETPLACE IN 2015

By Munira Z. Gunja and Emily R. Gee
September 23, 2014

A central feature of the Affordable Care Act is the establishment of the Health Insurance Marketplace ("Marketplace"). The Marketplace offers consumers a transparent and competitive platform to shop for health insurance coverage, apply for financial assistance, and purchase coverage without any medical underwriting or special premium adjustment based on pre-existing conditions.[1] Based on preliminary data available for 44 states, there will be 77 issuers offering Qualified Health Plans (QHPs) through the State-based and Federally-facilitated Marketplaces (also known as Marketplace plans) for the first time in 2015, and 36 of the 44 states will have at least one new Marketplace entrant. In these 44 states, there will be 63 more issuers offering Marketplace plans in 2015 than there were in 2014. This represents a 25 percent increase in the total number of issuers offering Marketplace plans between 2014 and 2015.

Key Findings

- Based on preliminary data for 36 Federally-facilitated Marketplace (FFM)[2] states and eight additional State-based Marketplace (SBM) states, there will be a 25 percent increase in the number of health insurance issuers offering Marketplace coverage in 2015 compared to 2014.
- Four of the 36 states in the FFM will have at least double the number of issuers they had in 2014.
- At least 67 issuers in the FFM and 10 issuers in the SBMs will be new to the Marketplaces in 2015.
- Some of the nation's largest insurers will be offering coverage for the first time in more than a dozen states, suggesting that the FFM and SBMs represent an increasingly attractive business opportunity

[1] This brief considers only individual market Qualified Health Plan (QHP) issuers, and not SHOP or stand-alone dental plan (SADP) issuers. SADPs offered through the Marketplace may still underwrite and adjust premiums.
[2] For the purposes of this analysis, we refer to 36 states collectively as the Federally-facilitated Marketplace. These 36 states include 27 states that have Marketplaces fully run by the federal government, 7 that have State Partnership Marketplaces, and 2 that have federally supported State-based Marketplaces in 2014.

- Ten issuers in the FFM and four issuers in the SBMs that offered QHPs in a given state in 2014 have not filed for participation in 2015; however, some of those issuers' parent companies continue to be active in the respective states' Marketplaces.
- Given that the number of new entrants is expected to be more than five times the number of exiting issuers among the 44 states included in this analysis, the Marketplaces will offer consumers significantly more choice in 2015 and appear to offer an increasingly attractive business opportunity for issuers.

Consumers who are shopping for Marketplace plans will be able to choose from among a significantly larger set of insurance issuers for 2015 than were available for 2014.[3] Market entry results in more sellers while typically driving issuers to compete more aggressively on price and quality.[4] This, in turn, offers consumers better value and more opportunity to pick the plan that best meets their needs.

Issuer Participation in the Marketplace

In 2014, there were 191 issuers[5] offering Marketplace plans in the 36 states with Marketplaces supported by or fully run by the Department of Health and Human Services (throughout this brief referred to as the FFM). Complete and final information on 2015 issuers was not yet available at the time of this analysis. Preliminary information from 2015 issuer filings to the Centers for Medicare & Medicaid Services (CMS) Center for Consumer Information and Insurance Oversight (CCIIO) indicates that a total of 248 issuers will be offering Marketplace plans in the FFM, as shown in Table 1.[6] This represents a 30 percent increase when compared with the 191 issuers offering Marketplace plans in these 36 states in 2014.

In the eight SBM states for which information was available, a total of 67 issuers will be offering Marketplace plans in 2015, compared to 61 issuers offering Marketplace plans in those states in 2014 (Table 2). This represents a 10 percent increase in the number of issuers offering Marketplace plans in those eight states.

Overall, there will be a 25 percent increase in the number of issuers offering Marketplace plans in 2015.[7] The number of issuers is at least doubling in four states in 2015: Indiana, Missouri, New Hampshire, and West Virginia. In 30 of the 36 FFM states, and in six of the eight SBM

[3] ASPE estimated that for 2014, 82 percent of people eligible to purchase a qualified health plan lived in rating areas with at least three issuers in the Marketplace, and 96 percent lived in areas with at least two issuers. For more information, see http://aspe.hhs.gov/health/reports/2014/Premiums/2014MktPlacePremBrf.pdf.

[4] For example, an ASPE analysis found that in 2014, "Competition, as measured by the number of issuers in a rating area, [was] associated with more affordable benchmark plans (the second-lowest cost silver plan) for individuals and reduced costs for the federal government," see http://aspe.hhs.gov/health/reports/2014/Premiums/2014MktPlacePremBrf.pdf.

[5] For the purpose of this analysis, we identify an issuer by its unique five-digit issuer Health Insurance Oversight System (HIOS) ID. In some cases, issuers with different HIOS ID numbers belong to the same parent company. An issuing entity's HIOS issuer ID is specific to the state in which it operates, such that a company offering QHPs through the Marketplace in two states would be counted twice—once for each state.

[6] Oregon and Nevada officials have announced that their state Marketplaces will be switching from SBMs to federally supported SBMs for 2015. Oregon and Nevada are not included in this analysis.

[7] This increase is based on the 44 states for which data was available for this analysis.

states for which we have data, there is at least one new Marketplace issuer. California is the only state among the 44 with a decrease in the number of issuers in 2015 (from 12 to 10).

Entry and Exit by Issuers in the Marketplace

Among the 36 FFM states, 67 issuers are expected to offer plans through the Marketplaces in those states for the first time in 2015. Indiana will have six new entrants in 2015, Ohio will have five new entrants, and Florida, Georgia, Michigan, Missouri, New Hampshire, and Pennsylvania will each have four new entrants. Among the eight SBM states with issuer data available, 10 issuers will be offering plans through the Marketplaces in those states for the first time in 2015. Colorado, Maryland, New York, and Washington will each have two new issuers entering their Marketplaces in 2015.

Among FFM states, Michigan, Ohio, and Texas are expected to have the greatest number of issuers in 2015 (16 issuers), followed by Pennsylvania and Wisconsin (15), and Florida (14). By comparison, in 2014, the greatest number of issuers in a state was 14 (Pennsylvania). While eight of the 36 FFM states had fewer than three issuers in 2014, only three FFM states are expected to have fewer than three issuers in 2015.

Among the eight SBM states for which we have data, New York has the greatest number of issuers in 2015 (17 issuers), followed by Colorado (12), and California and Washington (10). By comparison, in 2014, the state with the greatest number of issuers among these SBMs was New York (16).

Based on the preliminary issuer information for the 44 states included in this analysis, a total of 14 issuers that offered Marketplace plans in 2014 had not filed for Marketplace participation in 2015. We count these as "exiting" issuers. Based on the states for which information was available, ten issuers in the FFM and four issuers in the SBMs are not expected to participate in 2015. In at least six cases, however, the exiting issuer's parent company continues to participate in the state's Marketplace in 2015 through at least one other issuer.

Conclusion

Given that the number of new entrants is expected to be more than five times the number of exiting issuers among the 44 states included in this analysis, the Marketplaces will offer consumers significantly more choice for coverage in 2015 and appear to offer an increasingly attractive business opportunity for issuers.

Previous research has found that the number of issuers in a rating area is associated with more affordable premiums for benchmark plans (a four percent decrease in the premium of the second-lowest cost silver plan) for individuals and reduced costs for the federal government. Additionally, in 2014, areas with a larger number of issuers were found to offer a wider range of choices among plan types, such as preferred provider organizations (PPOs), health maintenance

organizations (HMOs), and consumer-operated and oriented plans (CO-OPS).[8] Furthermore, reports indicate that some of the largest insurers in the nation are increasing their participation in the Marketplaces in 2015.[9] Independent research has found that participation by a large issuer could significantly reduce benchmark premiums.[10]

TABLE 1. Number of QHP Issuers in 2014 Federally-facilitated Marketplace States (1)

State	Number of Issuers (2) (preliminary)*			Issuers Exiting in 2015 (preliminary)**	New Entrants in 2015 (preliminary)***
	2014	2015	Net Change from 2014 to 2015		
Alabama	2	3	1	0	1
Alaska	2	2	0	0	0
Arizona	10	13	3	0	3
Arkansas (3)	3	4	1	0	1
Delaware (3)	3	3	0	2	2
Florida	11	14	3	1	4
Georgia	5	9	4	0	4
Idaho (4)	4	5	1	0	1
Illinois (3)	8	10	2	1	3
Indiana	4	9	5	1	6
Iowa (3)	4	4	0	0	0
Kansas	4	5	1	0	1
Louisiana	5	6	1	0	1
Maine	2	3	1	0	1
Michigan (3)	12	16	4	0	4
Mississippi	2	3	1	0	1
Missouri	4	8	4	0	4
Montana	3	4	1	0	1
Nebraska	4	4	0	1	1

[8] See http://aspe.hhs.gov/health/reports/2014/Premiums/2014MktPlacePremBrf.pdf

[9] For example, see: Abelson, R., "Insurers Once on the Fence Plan to Join Health Exchanges in '15", *The New York Times*, May 25, 2014, available at http://www.nytimes.com/2014/05/26/your-money/health-insurance/insurers-once-on-the-fence-plan-to-join-health-exchanges-in-15.html

[10] Leemore Dafny, Jonathan Gruber, and Christopher Ody, "More Insurers Lower Premiums: Evidence from Initial Pricing in the Health Insurance Marketplaces," National Bureau of Economic Research working paper no. 20140, May 2014, available at http://www.nber.org/papers/w20140.

State	Number of Issuers (2) (preliminary)*			Issuers Exiting in 2015 (preliminary)**	New Entrants in 2015 (preliminary)***
	2014	2015	Net Change from 2014 to 2015		
New Hampshire (3)	1	5	4	0	4
New Jersey	4	6	2	0	2
New Mexico (4)	4	5	1	0	1
North Carolina	2	3	1	0	1
North Dakota	3	3	0	0	0
Ohio	12	16	4	1	5
Oklahoma	6	7	1	0	1
Pennsylvania	14	15	1	3	4
South Carolina	4	5	1	0	1
South Dakota	3	3	0	0	0
Tennessee	4	5	1	0	1
Texas	12	16	4	0	4
Utah	6	6	0	0	0
Virginia	8	9	1	0	1
West Virginia (4)	1	2	1	0	1
Wisconsin	13	15	2	0	2
Wyoming	2	2	0	0	0
FFM Total (36 states)	*191*	*248*	*57*	*10*	*67*

* Counts are from issuer filings in HIOS as of September 4, 2014. The number of issuers may not include issuers offering only multi-state plans.
** Exiting issuers represent issuers that offered a QHP through the Marketplace in a given State in 2014, but have not filed for participation in 2015.
*** New entrants represent 2015 issuers that did not offer QHPs through the Marketplace in a given State in 2014.
Source: Preliminary rate filings from the Center for Consumer Information and Insurance Oversight.
(1) Includes data for 36 states collectively known as the Federally-facilitated Marketplace. These 36 states include 27 states that have Marketplaces fully run by the federal government, 7 that have State Partnership Marketplaces, and 2 that have federally supported State-based Marketplaces in 2014.
(2) For the purposes of this analysis, an issuer represents a unique issuer identification number in the CMS Health Insurance Oversight System (HIOS). Because an entity's HIOS code is specific to each state, for purposes of this analysis, no issuer is counted as being active in more than one state.
(3) Arkansas, Delaware, Illinois, Iowa, Michigan, New Hampshire, and West Virginia are State Partnership Marketplaces for 2014.
(4) Idaho and New Mexico are federally supported SBMs for 2014 and utilize the FFM eligibility and enrollment platform.

TABLE 2. Number of QHP Issuers in 2014 Select State-based Marketplaces (1)

State	Number of Issuers (2) (preliminary)*			Issuers Exiting in 2015 (preliminary)**	New Entrants in 2015 (preliminary)***
	2014	2015	Net Change from 2014 to 2015		
California (3)	12	10	-2	2	0
Colorado (4)	10	12	2	0	2
Connecticut (5)	3	4	1	0	1
District of Columbia (6)	4	4	0	0	0
Maryland (7)	6	7	1	1	2
New York (8)	16	17	1	1	2
Rhode Island (9)	2	3	1	0	1
Washington (10)	8	10	2	0	2
SBM Total (8 states)	*61*	*67*	*6*	*4*	*10*

* Counts are from issuer filings and media reports as of August 2014. Data were unavailable for Hawaii, Kentucky Minnesota, Massachusetts, Nevada, Oregon, and Vermont.
** Exiting issuers represent issuers that offered at QHP through the Marketplace in a given State in 2014, but have not filed for participation in 2015.
*** New entrants represent 2015 issuers that did not offer QHPs through the Marketplace in a given State in 2014.
Source: Preliminary rate filings from the Center for Consumer Information and Insurance Oversight and additional sources as noted below.
(1) Includes data for eight states that have State-based Marketplaces in 2014 (excluding states with State Partnership Marketplaces and federally supported SBMs).
(2) For the purposes of this analysis, an issuer represents a unique issuer identification number in the CMS Health Insurance Oversight System (HIOS). Because an entity's HIOS code is specific to each state, for purposes of this analysis, no issuer is counted as being active in more than one state.
(3) "Covered California Announces Rates for 2015; Rigorous Negotiations with Health Insurance Companies Keep Rate Increases Low and Choices Robust." Covered California. July 31, 2014. Retrieved from http://news.coveredca.com/2014/07/covered-california-announces-rates-for.html#more
(4) "Division of Insurance Releases Preliminary Look at 2015 Health Plans." Colorado Division of Insurance. June 23, 2014. Retrieved from http://cdn.colorado.gov/cs/Satellite?blobcol=urldata&blobheadername1=Content-Disposition&blobheadername2=Content-Type&blobheadervalue1=inline%3B+filename%3D%22DOI+Release+Preliminary+Look+at+2015+Health+Plans.pdf%22&blobheadervalue2=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1252001286218&ssbinary=true
(5) "Connecticut Insurance Department – Current Rate Filings." Connecticut Insurance Department. Retrieved from http://www.catalog.state.ct.us/cid/portalApps/RateFilingComment.aspx
(6) Preliminary rate filings from the Center for Consumer Information and Insurance Oversight.
(7) "Public Comment Sought on Carriers' Proposed Health Rates for 2015." Maryland Insurance Administration. June 6, 2014. Retrieved from http://www.mdinsurance.state.md.us/sa/news-center/2015-proposed-health-rates.html
(8) Prakash, N. "Behind New York's 2015Health Insurance Rates." *Capital*. August, 4, 2014. Retrieved from www.capitalnewyork.com/article/albany/2014/08/8549028/behind-new-yorks-2015-health-insurance-rates
(9) "State of Rhode Island Office of the Health Insurance Commissioner: Requested and Approved Summary for 2015 Rates in the Individual, Small Group, and Large Group Markets." Rhode Island Health Insurance Commissioner. Retrieved from

http://www.ohic.ri.gov/2014%20Rate%20Review%20Final%20Decision/2_2014%20Rate%20Review%20%20All%20Market%20Requested%20and%20Approved%20Summary.pdf
(10) Kreidler, M. "90 health plans approved for next year's Exchange with a record low 1.9 percent rate change." Washington State Office of the Commissioner. August 27, 2014. Retrieved from http://insurance.wa.gov/about-oic/news-media/news-releases/2014/8-27-2014.html

Methodology

For the purposes of this analysis, we define an issuer as an entity offering one or more individual market QHPs[11] through a Marketplace (Marketplace plans) and count as a separate issuer each unique issuer identification number in the Health Insurance Oversight System (HIOS) of the Centers for Medicare & Medicaid Services' Center for Consumer Information and Insurance Oversight. An entity's HIOS code is specific to each state. Based on this definition, for purposes of this analysis, no issuer is counted as being active in more than one state. The number of 2014 and 2015 issuers was tabulated by CCIIO from information in HIOS and supplemented with information from the FFM plan landscape file, publicly available issuer filings, state press releases, and media reports.[12]

We consider an issuer to be a "new entrant" in 2015 if it did not participate in a given state's Marketplace in 2014 based on its HIOS ID number, and we define "exiting" issuers as those which were active in a given state in 2014 but have not filed for participation in 2015.

The 2015 data reported here were available as of September 4, 2014, and are preliminary and incomplete. Not all states and issuers have submitted information to HIOS. The QHP certification process had not yet been completed at the time of this analysis.

The total number of issuers in a state, as shown in Tables 1 and 2 does not necessarily reflect the amount of choice available to each individual consumer. Some issuers' service areas do not include the entire state; therefore, the number of issuers offering plans in a given rating area is typically less than the total number of issuers that are active in a state.

This brief considers only individual market QHP issuers, and it does not reflect data for SHOP or stand-alone dental plan issuers.

[11] This brief considers only individual market Qualified Health Plan (QHP) issuers, and not State Health Options Plan (SHOP) or stand-alone dental plan (SADP) issuers.
[12] To verify the number of 2014 issuers, we used the January 2014 version of the FFM plan landscape file publicly available at: https://www.healthcare.gov/health-plan-information.

ITUP
INSURE THE UNINSURED PROJECT

What's Ahead for Covered California?
Medium-Term Policy Considerations
Prepared by Carolina Coleman
September 2014

Coordinating Medi-Cal and Covered California Enrollment

California has faced considerable difficulty activating Medi-Cal coverage for many low-income Californians. The state accumulated a backlog of 900,000 pending Medi-Cal applications in May 2014, although this was reduced to 600,000 in July and 250,000 in September. [1] [2] The causes of this backlog are numerous, including state requirements of verification of eligibility criteria, the large volume of Medi-Cal applications, and extensive technological issues including the limited interface between CalHEERS and the multiple county eligibility systems (SAWS), inaccurate and/or incomplete programming of eligibility rules, and issues connecting to the federal data hub used for verification. While Medi-Cal eligibility is supposed to be finalized within 45 days of the application filing, this standard has not been met. Changes to the eligibility determination process are needed to enroll consumers in coverage in a timely manner.

When individuals who apply for coverage through CalHEERS are found to be within the Medi-Cal income thresholds their applications are transferred to county district offices, and Covered California is no longer involved. While Covered California applicants receive nearly instant eligibility determinations, Medi-Cal applications await review sometimes for months without status updates, and then are often followed with requests for paper documentation of eligibility criteria. Because of technological and policy limitations of both SAWS and CalHEERS, county workers are forced to use workarounds, toggle between both systems, and manually alter data, all very time-consuming tasks that cause delays. This process does not follow the 'no wrong door' approach, in that the experiences of the Medi-Cal and Covered California eligible are completely different and unequal.

Burdens upon both county offices and consumers should be reexamined and alleviated when appropriate to streamline the eligibility determination process and quickly review applications. The State requires county Medi-Cal offices to verify income, immigration status, and California residency (although the latter has been recently waived – a significant improvement given that CalHEERS and the federal hub cannot verify this electronically, thus mandating paper verification for all Medi-Cal applicants) before eligibility can be determined. While the ability to submit verification documents online has eased the process somewhat, it is still time-consuming and burdensome to consumers and adds to the already heavy workload of eligibility workers, particularly when the technology proves problematic, thus delaying decisions. Documents to verify eligibility can also be requested of Covered California-eligible applicants, however Covered California does not verify and reconcile all inconsistencies from self-attestation and the federal data hub, and enrollment can be activated before inconsistencies are verified.[3]

---

[1] Eryn Brown (2014). Backlog of Medi-Cal Applications under Obamacare Cut to 600,000. Los Angeles Times. Retrieved from: http://www.latimes.com/local/lanow/la-me-ln-medi-cal-backlog-update-20140703-story.html

[2] David Gorn (2014). Medi-Cal Application Backlog Will Be 'Down Significantly' Within Six Weeks. California Healthline. Retrieved from: http://www.californiahealthline.org/capitol-desk/2014/9/medical-application-backlog-will-be-down-significantly-within-six-weeks

[3] Office of the Inspector General, U.S. Department of Health & Human Services (2014). Not All Internal Controls Implemented by the Federal, California, and Connecticut Marketplaces Were

Verifications for both Medi-Cal and Covered California should be minimized to the extent possible under the law. SB 677 and Welfare and Institutions Code 15926.2 states that "all insurance affordability programs may accept self-attestation, instead of requiring an individual to produce a document for age, date of birth, family size, household income, state residence, pregnancy, and any other applicable criteria needed to determine the eligibility of an applicant or recipient, to the extent permitted by state and federal law.[4] [5] This statute expressly allows DHCS to establish a more streamlined process that minimizes burdens on county offices and consumers.

Additionally, stakeholders have expressed numerous concerns that consumers are being incorrectly denied Medi-Cal, often because of the absence of rules programmed into the systems and insufficient communication from the State regarding eligibility for certain immigrants and special groups like former foster youth. Some individuals have been assigned to limited scope or Share of Cost, or put through outdated standards like the asset test, due to the incorrect use of aid codes for pregnant women, parents, and disabled individuals rather than the streamlined modified adjusted gross income (MAGI) standard for adults under 138% of the federal poverty level. The counties need clear guidelines and streamlined procedures in order to make accurate and timely determinations.

Recommendation: *1) Provide presumptive eligibility to consumers with applications pending more than 45 days, 2) allow for self attestation while verifications are being processed, 3) improve eligibility systems with correct rules and procedures, and 4) issue clear guidelines to counties and consumers on eligibility criteria*

While delays were inevitable during such a large-scale shift in the healthcare system as the ACA, individuals are legally entitled to an eligibility decision within 45 days. If this cannot be promised under the current system, the procedures should be altered. In an ideal world, Medi-Cal and Covered California determinations would be made by one system that relies exclusively on electronic verifications and offers near instant decisions. In reality, this may not be possible. It is likely that tech issues that delay determinations and care will continue, but steps can be taken to streamline systems, correctly program them with up-to-date rules, and rely on electronic sources of data verification including the federal hub, DMV, and other government offices. Improving the technology must be made an absolute priority when issues create barriers to coverage and care.

In the absence of a perfect eligibility system, accommodations to eligibility workers and consumers must be made. ITUP recommends that paper verifications be minimized. When eligibility cannot be verified electronically or there are discrepancies,

---

Effective in Ensuring That Individuals Were Enrolled in Qualified Health Plans According to Federal Requirements. Retrieved from: https://oig.hhs.gov/oas/reports/region9/91401000.pdf

[4] A2 of Section 14005.30(a2) of the Welfare and Institutions Code directs the Department of Health Care Services to "adopt less restrictive income and resource eligibility standards and methodologies" for Medi-Cal.

[5] AB 43 would have amended Section 15926.2 of the W&I code to read "state health subsidy programs shall accept an individual's attestation, without further documentation from the individual, for age, date of birth, family size, household income, state residence, pregnancy, and any other applicable eligibility criteria for which attestation is permitted by federal law." However it died in 2012.

documentation should be requested, with self-attestation under the penalty of perjury permitted if no documentation is easily available. While some may feel that self-attestation allows for fraud, the State must consider the cost of reviewing documents for every application and the impact and costs associated with delayed care. Additionally, county employees need intensive training on MAGI standards, eligible immigration statuses, the interactions between Medi-Cal and Covered California, and proper determinations procedures. DHCS should issue clear guidelines to counties on who is eligible for the program and how to quickly enroll them.

Most importantly, ITUP recommends that provisional eligibility for Medi-Cal be granted absolutely after 45 days, but preferably in a shorter timeframe, to consumers who apply via CalHEERS and claim to be within the income threshold. This will grant access to care to individuals while the county offices make final determinations. Under this option, additional state oversight of Medi-Cal offices is necessary to ensure that final eligibility decisions are delivered in a timely and accurate manner.

Optimizing the SHOP

The Small Business Health Options Program (SHOP) in Covered California is off to a slow start. By June 2014, only 1,587 groups, covering 10,497 lives, were enrolled, totaling less than 1% of the enrollment in the individual Exchange.[1] For the SHOP to become self-sufficient and achieve a balanced risk pool, it must greatly expand in a short period of time. To do this, SHOP must entice groups of small employers to offer coverage for the first time and must also demonstrate the Exchange's value to employers who already offer coverage.

There is certainly opportunity for expansion, given relatively low offer rates (76% of business with 10 to 49 employees), high uninsured rates (31%) among employees of small business, and ongoing concerns about cost from firms that do offer health insurance.[2] [3] [4] Many of the SHOP's qualities – employee choice, comprehensive coverage, tax credits for very small and low-wage firms, and lower than average rates – seem easily marketable. But extensive barriers such as limited awareness of the SHOP, availability of alterative coverage options (direct enrollment and private exchanges), the two-year limitation on the tax credits, narrow agent buy in, and, of course, affordability concerns could stall growth. Additionally, much of Covered California's focus has fixed on the individual Exchange, and the SHOP has been plagued with administrative and technological issues that have delayed enrollment activations. Efforts in progress to improve the enrollment process, engage agents, and market to the small business community will hopefully boost enrollment in the coming months, however the vision for the SHOP needs refinement.

Streamline Enrollment and Build Online Portal

Following the shutdown of the online portal, SHOP enrollment shifted to paper applications and a platform created by Pinnacle Claims Management, the SHOP administrator. The administrative process for enrollment is slow; it can take months for coverage to be activated, with similar delays for adding new employees. The revamped online portal, in which employers can sign up for SHOP and employees can view their options and select a plan, has yet to be rebuilt or even planned. The lengthy and unclear activation timelines and paperwork requirements have likely discouraged small businesses from participating in the SHOP, and agents from selling SHOP plans. Until the enrollment process is greatly improved, the SHOP will not be an attractive option to small businesses, agents will direct their customers elsewhere, and the competition with private exchanges will be stiff. All of the following steps cannot occur until the enrollment process is clear, simple, speedy, and online. Covered California should streamline the enrollment process for businesses and employees to remove barriers and quickly activate coverage. This must be prioritized to maximize enrollment.

---

[1] Covered California Small Business Health Options Program Advisory Group August 6, 2014 meeting. Presentation slides. Retrieved from: http://hbex.coveredca.com/stakeholders/shop/PDFs/SHOP PPT.pdf

[2] California HealthCare Foundation (2014). California Health Care Almanac - California Employer Health Benefits Survey: Workers Feel the Pinch. Retrieved from: http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/E/PDF%20EmployerHealthBenefits2014.pdf

[3] Kaiser Family Foundation (2014). The Uninsured: An Interactive Tool. Retrieved from: http://kff.org/interactive/the-uninsured-an-interactive-tool/

[4] McLaughlin, C., & Swinburn, A. (2014). Small Business and Health Reform: Results From a Survey of Five States. Mathematica Policy Research. Retrieved from: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf412363

Enhance Agent Involvement

Although 78% of groups in SHOP enrolled via brokers, total agent involvement is limited.[5] Only 699 agents have sold SHOP products, compared to more than 12,000 brokers certified to sell plans in the individual Exchange. [6] [7] Agents have long driven sales in the small group market, and it will be difficult for the SHOP to succeed without buy-in from them. After the enrollment process is improved, Covered California must conduct extensive outreach to agents and treat them as partners to gain their attention and trust. SHOP must demonstrate its value to the agent community, solicit more feedback on outreach strategies and plan offerings, transparently notify brokers of any issues, and pay agent commissions on time. Additionally, agents undergoing certification to sell individual plans in Covered California should receive training on the SHOP so that the benefits of the program become widely known.

Lower Plan Prices and Expand Firm Size

Although the SHOP is open to employers with up to 50 full time equivalent employees, early enrolled firms are very small employers; 93% of groups employ 10 or fewer individuals, and 75% employ fewer than six employees.[8] This trend is intriguing, although not surprising, given that these groups include businesses that can take advantage of the tax credits available, depending upon their average wages. The SHOP will need to pull in a more diverse group of small employers in the coming months and years through marketing efforts and agent collaboration. However, plan pricing is the defining factor in enrollment, as illustrated in the individual Exchange, and the current prices in SHOP are expensive for some small employers, many of which historically purchased inexpensive plans with limited benefits.[9] Because of the low initial enrollment figures, the SHOP faces a "chicken or the egg" dilemma: more participation is needed for the SHOP to negotiate lower prices, yet lower prices are needed to boost participation. This issue may be mitigated in the coming year as non-ACA compliant plans renewed early in 2013 (and again in 2014) expire, and small businesses purchase more robust plans.

To further lower prices, the SHOP may be able to capitalize on Covered California's individual Exchange. Covered California policy originally required plans that participate in the individual Exchange to also participate in SHOP if they are licensed to sell in the small group market, with exceptions for the local initiatives that have previously focused solely on Medi-Cal managed care.[10] However in 2013 the Exchange allowed Anthem Blue Cross to withdraw from the solicitation process only for SHOP.[11] This lenient policy may be inflating prices. Covered

---

[5] SHOP Advisory Group August 2014 meeting, op. cit.
[6] Ibid.
[7] Covered California May 2014 board meeting: Executive Director's Report. Retrieved from: http://board.coveredca.com/meetings/2014/5-22/PDFs/PPT - Executive Director's Report_May 21, 2014.pdf
[8] SHOP Advisory Group August 2014 meeting, op. cit.
[9] Day, R., Nadash, P., Hrycko, A. (2014). The Evolution of a Two-Tier Health Insurance Exchange System. Health Affairs Blog. Retrieved from: http://healthaffairs.org/blog/2014a/08/13/the-evolution-of-a-two-tier-health-insurance-exchange-system/
[10] California Health Benefit Exchange Board June 12, 2012 meeting minutes. Retrieved from: http://board.coveredca.com/meetings/2012/PDFs/II-1_CHBE6-12-12MeetingMinutes_8-23-12.pdf
[11] Kathy Robertson (2013). Anthem Blue Cross Withdraws From Covered California Small Biz Marketplace. Sacramento Business Journal. Retrieved from:

California has the ability to require plans to offer in both Exchanges and could potentially pressure carriers to offer competitive rates in SHOP to improve enrollment.

States have the option to allow employers with up to 100 employees to participate in the SHOP, and must allow these firms by 2016.[12] In 2017, employers with more than 100 employees may participate in SHOP at state option.[13] Including larger employers in the SHOP would strengthen the risk pool and potentially reduce costs. Midsize and larger employers could be drawn by the allure of employee choice of carrier and plan, and the reduction of administrative duties. Because of its potential to lower costs and expand coverage, Covered California should take steps to open up the SHOP to larger employers. Although without underwriting reforms, such as guaranteed issue and renewal, in the midsize and large group markets, adverse selection in the SHOP is a distinct possibility as it expands firm size.

Expand Plan Offerings and Benefit Design

In the individual Exchange, consumers may chose from up to six carriers, varying by region, in four metal tiers, while in the SHOP, employees can choose from three or four carriers in two tiers.[14] While this level of employee choice is certainly greater than that of the average small business plan, some have called for expanded plan options in the SHOP. The value of choice is the key feature of SHOP, and this would grow if the number of carriers participating grew. There are far more carriers available outside of SHOP, including in private Exchanges, which limits SHOP's appeal. Covered California should consider outreach to carriers that do not currently offer in SHOP, potentially even carriers that do not offer in the individual Exchange, but should do so carefully, in that expansive plan options amongst a small risk pool could potentially create new barriers to enrollment (through employees overwhelmed with options) and could encourage adverse selection.[15] It could be beneficial to incentivize Medi-Cal managed care plans to participate in SHOP to mitigate the negative impacts of churn through continuity of care, although it may be challenging to entice these plans to offer in an unfamiliar market.

Carriers should also be encouraged to offer alternative benefit designs, with up to three options within a tier. Alternative benefit designs may be able to achieve lower prices that will draw in small businesses, although plans should still be held to minimum levels of comprehensive benefits. Standardization of plans in the individual Exchange is key because consumers have choice of tier; however, given the tier restrictions in SHOP, employees could benefit from additional choices.

Offer Additional Services

Small businesses are looking for one-stop shops that can achieve administrative simplicity and efficiency. If SHOP, in partnership with Pinnacle and/or other contractors, can offer additional services like the administration of wellness programs, life insurance, even payroll, then this would be very attractive to small organizations that lack human resources departments. While not the fundamental purpose of SHOP, offering these additional benefits may be necessary for it

---

http://www.bizjournals.com/sacramento/news/2013/07/19/anthem-blue-cross-withdraws-covered-cali.html?page=all

[12] PPACA § 1304(b).

[13] PPACA § 1312(f)(2)(B).

[14] 'Paired' tier choice is expected in fall 2014.

[15] California Health Benefit Exchange (2012). Small Employer Health Options Program Discussion Draft – Options and Recommendations. Retrieved from: http://board.coveredca.com/meetings/2012/06 Jun-12 Meeting Materials/PDFs/CHBE-SHOPExchange-BoardOptions-05-18-12FINAL.pdf

to compete with private exchanges. The Board adopted a staff recommendation to "explore vendor options for COBRA, IRS 125, FSA and HSA" and supplemental vision and dental plans in 2012; however, this has yet to be pursued.[16]

The natural first step is for SHOP to offer stand-alone vision and dental plans. A full package of benefits is often offered to employees, and obtaining full coverage from one administrative source is desirable. Covered California should then conduct a feasibility study to determine what services are both desired by small businesses and cost-effective to offer.

[16] California Health Benefit Exchange (2012). Small Employer Health Options Program Final Board Recommendations. Retrieved from: http://board.coveredca.com/meetings/2012/08%20Aug-23%20Meeting%20Materials/PDFs/VIII-A_CHBE-SHOPExchangeBoardRecommendationsBriefs_8-23-12.pdf.

Standardized Benefits in Covered California Plans

Covered California created a set of standardized benefits for its first plan year. Plans in each metal tier have set deductibles, copay structures (with some differences between copay and coinsurance plans), and out-of-pocket maximums. Carriers must offer a plan in each tier and are limited in the number of plans that can be offered.[1] The standardization allows consumers to make apples-to-apples comparisons of plans based on their differing premiums, prescription drug formularies, and provider networks. Covered California's board and executive director declared the 2015 plan year one of 'stability' and did not make substantial changes to the standardized benefit design; however, the Board has expressed a willingness to consider allowing carriers to submit alternative benefit designs in future years, and some have called for changes to the plan offerings to allow for expanded consumer choice and/or lower cost sharing.

Few other states have opted to standardize plan benefits. In the federally-administered Exchanges, carriers are free to offer multiple plans in some tiers but not offer in others, and do not have to structure benefits and cost sharing in a uniform manner. As a result, consumers are faced with a plethora of plan options that vary considerably in benefits. Consumers in federally-administered states have 53 plan options on average in 2014, with as many as 169 plans available in some regions.[2] For example, in Miami nine carriers offer a total of 137 plans (40 Bronze, 48 Silver, 34 Gold, and 15 Platinum). The cost sharing varies greatly, with completely different deductibles, co-pay/coinsurance schedules, and out-of-pocket maximums amongst plans even in the same tier (see table below). By comparison, Los Angeles residents may choose from a total of 30 plans with standard cost sharing that only varies by tier.

Plan Offerings and Design					
		Bronze		Silver	
Location	Number of plans (four metal tiers)	Highest Deductible	Lowest Deductible	Highest Deductible	Lowest Deductible
Miami	137	$6,350	$3,500	$5,750	$0
Phoenix	111	$6,350	$3,000	$5,000	$1,500
Los Angeles	30	$5,000	$5,000	$2,250	$2,250

The extensive offerings in other regions are likely confusing and overwhelming to consumers. Advocates have argued that too many plan choices are intimidating and frustrating to individuals who may not be able to spend hours analyzing the differences between 50 or more plans.[3] Considering that most Americans do not understand basic

[1] Kaiser Family Foundation (2013). State Marketplace Profiles: California. Retrieved from: http://kff.org/health-reform/state-profile/state-exchange-profiles-california/
[2] Department of Health and Human Services (2013). ASPE Issue Brief: Health Insurance Marketplace Premiums for 2014. Retrieved from: http://www.whitehouse.gov/sites/default/files/docs/marketplace_premiums_ib_final.pdf
[3] California Health Benefit Exchange (2012). The California Path to Achieving Effective Health Plan Design and Selection and Catalyzing Delivery System Reform: Stakeholder Input on Key

health insurance concepts,[4] many consumers are unable to decipher the advantages and disadvantages of plans that vary across dozens of cost sharing elements in addition to the multitude of other factors (provider network, drug formulary, etc.) one should consider in plan selection.

The overload of information and choices makes selecting the most appropriate plan for an individual's unique situation challenging. A study of Medicare enrollees found that more than 90% of seniors enrolled in Part D plans in which they paid more in premiums and cost sharing combined compared to other plans that offered additional savings based on their individual needs, costing seniors between $360 to $520 annually on average.[5] Seniors selected from between 27 to 70 plan options; this extensive range of choice may have prevented Medicare members from selecting the most affordable plan given both premiums and cost sharing. When surveyed, 60% of enrollees favored more limited offerings of plans that met certain minimum standards.

Covered California has helped consumers by limiting the number of plan offerings. Requirements of carriers, like offering a plan in each tier and limiting how many plans can be offered, are essential to maintaining clarity and simplicity in enrollment. Standardization of cost sharing makes tier choices distinct, streamlined, and transparent, so that consumers can weigh finite factors like provider networks and premiums amongst carriers, while considering the clear tradeoffs between tiers.

Standardization is particularly important in the Silver tier, as the second lowest cost Silver plan determines the amount of premium assistance offered. If Silver plans offer different benefits and cost-sharing requirements, plans with fewer benefits and/or higher cost-sharing could reduce the price of the lower cost Silver plans, in turn lowering the amount of premium assistance available to individuals seeking comprehensive benefits and manageable cost sharing obligations.[6]

The current Silver plan structure emphasizes preventative care by focusing cost sharing on high-cost inpatient services (most outpatient services are not subject to the $2,000 medical deductible).[7] This design is incredibly well crafted to focus on both affordability and appropriate use of services and was recently identified as a best practice for Exchanges.[8] Additionally, these exemptions counter arguments from consumer

---

Strategies. Retrieved from: http://board.coveredca.com/meetings/2012/05 May-22 Meeting Materials/PDFs/HBEX-QHPStakeholderReport_5-18-12.pdf

[4] Sarah Kliff (2013). Do You Understand Health Insurance? Most People Don't. Washington Post Wonkblog. Retrieved from: http://www.washingtonpost.com/blogs/wonkblog/wp/2013/08/08/do-you-understand-health-insurance-most-people-dont/

[5] Jonathan Gruber (2009). Choosing a Medicare Part D Plan: Are Medicare Beneficiaries Choosing Low-Cost Plans? Kaiser Family Foundation. Retrieved from: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7864.pdf

[6] Coursolle, A., & Lewis, K. (2013). Covered California Qualified Health Plan Model Contract Version 3.0. National Health Law Program. Retrieved from: http://www.healthlaw.org/about/staff/kim-lewis/all-publications/covered-california-qualified-health-plan-model-contract-version-30 - .U7GrWaieXmA

[7] Covered California (2014). 2015 Standard Benefit Plan Designs. Retrieved from: http://board.coveredca.com/meetings/2014/4-17/PDFs/Standard Benefit Plan Designs 9.5 EHB.pdf

[8] Families USA (2014). Designing Silver Health Plans with Affordable Out-of-Pocket Costs for Lower- and Moderate-Income Consumers. Retrieved from:

advocates that the deductibles in Covered California plans encourage individuals to delay or forgo care. While this is certainly a concern regarding traditional high deductible plans, the deductible exemptions in Covered California allow consumers to receive routine outpatient care with just the plan's copay for that service, while maintaining low premiums. This structure should be continued, but the low cost sharing for outpatient services should be more prominently featured and made unambiguously clear to enrollees.

Recommendation: *Continue the standardized benefit design with minor tweaks*

Covered California should continue to require carriers to adhere to standardized benefit structures that differ by tiers. The current metal tier structure allows consumers to choose from an appropriate number of options in which the differences are clear. In general the cost sharing obligations are fair and easy for consumers to understand and make informed choices, although continued education is needed to improve health literacy. In particular, the deductible exemptions in Bronze and Silver plans should be made explicitly clear to enrollees.[9]

The one aspect of the benefit design that should be altered is the use of coinsurance, which requires individuals to pay a percentage of a price for a service that is unknown until billed. While consumers can hypothetically contact providers for the negotiated rates, in practice this information is very challenging to acquire, and it is not possible to predict potential complications that would expand the scope of services billed. Coinsurance is currently used in HSA plans and for some high-cost services like specialty drugs and inpatient care in standard plans. The use of coinsurance is problematic because individuals cannot make informed healthcare choices if they don't know the cost of services. Insurance carriers have the right to impose higher cost sharing for more expensive services; however, this should be done through copays, which are more transparent and easy to understand.

While ITUP recommends that very few changes be made to the standardized benefit design, concerns from consumers, advocates, and the Department of Managed Health Care about the adequacy of provider networks in Covered California plans may warrant additional offerings. The Board should consider encouraging plans to offer broader network options in additional plans to consumers who value greater choice of providers and are willing to pay more – e.g., two plans offered by the same carrier in the same tier with "wide network" and "narrow network" designations. It is unclear if carriers will be interested in offering such plans given that enrollment in them may be adversely selected.

---

http://familiesusa.org/sites/default/files/product_documents/ACT_Assessing Alternatives Silver Plans Designs Brief_final_web2.pdf

[9] Enrollees in Bronze plans are entitled to three primary, mental health, and/or urgent care visits that are not subject to the deductible. In Silver plans, most outpatient services including primary and specialty care, lab testing, and x-rays are exempt from the deductible. However these exemptions are little known. Covered California 2014 Standard Benefit for Individuals. Retrieved from: http://www.coveredca.com/PDFs/standard-benfits-for-individuals.pdf

ITUP
INSURE THE UNINSURED PROJECT

What's Ahead for Covered California?
Medium-Term Policy Considerations
Prepared by John Connolly
September 2014

Transforming the Health Care Marketplace by Promoting Value

Covered California has a great deal of potential to transform the broader health coverage marketplace across the state. It can continue to use its negotiating power, with its pool of 1.4 million consumers,[1] to get the greatest value for consumers from their health plans—one of the core elements of its mission.[2] While the central goals in Covered California's negotiations are affordable premiums and ultimately better health for consumers, its contracting strategy should increasingly include payment designs that most effectively bring about those results.

Covered California has already laid a foundation for a strong quality strategy, including a rating system for participating plans, which it used to publish quality scores two years before it was required to do so under the ACA.[3] Covered California currently displays scores from the Consumer Assessment of Healthcare Providers and Systems (CAHPS), and they include information about customer service, making appointments for care, testing and treatment, and medical care.[4] This move was an important early start in developing a comprehensive and assertive quality strategy, and Covered California plans to expand upon these ratings, adding more provider-specific quality information and nationally standardized data when required in 2016.[5] Improving and expanding this quality rating system will be important to allow consumers to choose among plans based on their value, and to motivate plans and providers to improve performance.

Covered California's Qualified Health Plan Contract (hereafter referred to as "the Contract") for 2014 also includes a strong quality component that should serve as a starting point for a very effective longer-term quality strategy. In the Contract, plans must have NCQA or URAC accreditation,[6] report HEDIS and CAHPS scores,[7] and submit eValue8 data.[8] Moreover, plans must agree to promote the Triple Aim (increasing quality, reducing costs, and improving health outcomes),[9] participate in one or more

---

[1] Covered California (2014). Covered California's Historic First Open Enrollment Finishes with Projections Exceeded; Agents, Counselors, Community Organizations and County Workers Credited as Reason for High Enrollment in California. Retrieved from: http://news.coveredca.com/2014/04/covered-californias-historic-first-open.html
[2] Covered California (2014). Retrieved from: https://www.coveredca.com/about/
[3] U.S. Department of Health and Human Services (2014). Final Rule: Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond. Retrieved from: https://www.federalregister.gov/articles/2014/05/27/2014-11657/patient-protection-and-affordable-care-act-exchange-and-insurance-market-standards-for-2015-and - h-91
[4] Covered California (2014). Covered California Consumers Can Now Use Quality Rating System When Choosing a Health Care Plan. Retrieved from: http://news.coveredca.com/2014/01/covered-california-consumers-can-now.html
[5] Ibid.
[6] NCQA (the National Committee for Quality Assurance) and URAC are both nationally recognized quality evaluation and accreditation organizations.
[7] eValue8 is a tool "measure and evaluate health plan performance," and it created by the National Business Coalition on Health. For more information, see http://www.nbch.org/eValue8
[8] Covered California (2013). Qualified Health Plan Contract. Retrieved from: http://hbex.coveredca.com/solicitations/QHP/library/QHPModelContract-Final.pdf
[9] Institute for Healthcare Improvement. The IHI Triple Aim. Retrieved from: http://www.ihi.org/Engage/Initiatives/TripleAim/pages/default.aspx

statewide and national collaborative quality initiatives, and report the share of providers participating and consumers served within quality initiatives.[10]

The Contract also includes more aspirational elements, such as encouraging plans to promote Patient-Centered Medical Homes and Accountable Care Organizations (both are defined and discussed below), as well as many other care models that "promote access and care coordination."[11] Very importantly, Covered California also requires plans to report any ongoing value-based initiatives by the end of 2014, and to "develop and/or implement alternative reimbursement" models by January 1, 2016.[12] These planks of the Contract establish an excellent framework for a more specific and ambitious strategy to improve value in California's health insurance market.

Covered California should absolutely build on this foundation to further motivate plans to offer high quality at a competitive price. As the Contract mentions, the Medicare program and commercial insurers have begun to test and implement new payment models that offer incentives for value and not just volume of services. These models include private insurers' pay-for-performance and reference pricing strategies, and Medicare's diagnosis-related payments and bundled payments.

In 2012, Massachusetts also began implementing a new statewide payment reform strategy that emphasized many of these approaches, and essentially ended fee-for-service (FFS) payment in state-funded coverage programs.[13] While Covered California is not a direct payer for health services like the Massachusetts programs, very strong plan enrollment in its first year demonstrates its influence as an active purchaser negotiating with plans in the insurance market. In fact, researchers predict that Covered California's enrollment will increase in the coming years.[14]

Covered California ought to use its negotiating power to incorporate more specific requirements and incentives for implementing value-based insurance designs into the terms of participation for health plans that have not already adopted them. Although some payment approaches may be more feasible to implement in the near future than others, Covered California could use many of its already established data-reporting requirements to begin to influence insurers' practices through increased transparency. These efforts should shed light on how plans pay providers, and eventually provide a basis for financial incentives for plans to phase in new payment models.

In the longer term, as such a large purchaser of coverage, Covered California could have the market power to precipitate a broad, statewide shift to phase out fee-for-service payment. It should build purchasing coalitions with other large purchasers of coverage to expand "pay for value" strategies across the healthcare marketplace that could control overall spending and improve health outcomes for all Californians.

---

[10] Covered California Qualified Health Plan Contract, op. cit.
[11] Ibid.
[12] Ibid.
[13] John Connolly (2012). Health Care Reform in Massachusetts: Act II. Insure the Uninsured Project. Retrieved from: http://itup.org/wp-content/uploads/downloads/2012/08/MassReformFinal1.pdf
[14] UCLA Center for Health Policy Research, UC Berkeley Center for Labor Research and Education (2014). CalSIM Version 1.91 Statewide Data Book. Retrieved from: http://healthpolicy.ucla.edu/publications/Documents/PDF/2014/calsimdatabook-may2014.pdf

The following section of the brief outlines some of the approaches that Covered California could explore with participating insurers and partners in potential purchasing coalitions. We also propose incentives that Covered California could create that could drive this movement to pay-for-value models.

Pay for Value Models and Initiatives

Quality reporting is a foundation of paying for value in health insurance because rewarding quality requires information about performance. While the U.S. Department of Health and Human Services indicated that it will require state Exchanges to publish nationally standardized HHS quality ratings for its plans in 2016, it will also allow states to display their own quality scores that include additional information.[15] The Integrated Healthcare Association (IHA) has done foundational work to test and implement pay-for-value models among participating provider coalitions in California. In fact, IHA created the largest private quality performance incentive program in the country; it includes 200 physician groups, 35,000 physicians, and 7 health plans.[16] IHA has also done pioneering work to implement bundled payments within commercial insurance networks in California. (See below for more in-depth discussion of these payment reforms.) Covered California lists these IHA initiatives in its plan contract as two of the quality collaboratives from which plans can choose. It ought to collaborate closely with IHA and other quality collaboratives to explore value-based payment models that have been successful, and which approaches could be implemented more easily by Covered California plans, perhaps in a stepwise approach or in particular regions where it is feasible. These payment models could be based on the nationally standardized federal quality rating system for Exchange plans, or on IHA's quality ratings, which many California providers already use.

Pay for Performance

Pay-for-performance (P4P) is a model that links a portion of providers' payments to quality or cost performance measurements. P4P typically offers incentives based on structures, processes, outcomes, and consumer experiences that are associated with better health and lower costs.[17] As mentioned above, IHA has also done some very important work to implement this payment model in California. The evaluation incorporates 73 quality measures across the domains of clinical quality, patient experience, meaningful use of information technology, and appropriate resource use.[18] While health plans determine the structure and size of providers' financial incentives, IHA assigns a standardized performance score for all participating providers.

Covered California could move toward offering financial incentive to plans that report a standardized IHA quality rating for their contracted providers. The Exchange could also give plans with these P4P programs a special designation when they are displayed for consumers on the Exchange's website and informational materials. Eventually, future

---

[15] U.S. Department of Health and Human Services, op. cit.
[16] Integrated Healthcare Association (2014). Retrieved from: http://www.iha.org/p4p_california.html
[17] Julia James (2012). Health Policy Brief: Pay-for-Performance. Health Affairs. Retrieved from: http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=78
[18] Integrated Healthcare Association (2013). Pay-for-Performance (P4P) Program Fact Sheet. Retrieved from: http://iha.org/pdfs_documents/p4p_california/P4P-Fact-Sheet-September-2013.pdf

plan contracts could include these incentives for plans that have pay-for-performance programs while allowing insurers to have flexibility with regard their specific structure (e.g., the size of performance bonuses and the services or specialties to which they would apply).

Health Homes or Medical Homes

A Patient-Centered Medical Home (PCMH) is a model of primary care that provides coordinated and comprehensive care across a multi-disciplinary team that accommodates and incorporates each patient's needs, culture, and preferences.[19] Implementing PCHMs has been demonstrated in a number of studies to improve quality outcomes and reduce costs.[20] Insurance plans have begun to implement this model in their provider networks to achieve the quality and efficiency improvements that it can deliver.

Plans across the county have also created and tested incentives to establish medical homes and primary care case management in the context of pay for performance. For example, Horizon Blue Cross Blue Shield of New Jersey has adopted a program that combines medical homes with P4P in which primary care providers receive a per member per month payment for care management as well as a per member per month performance-based payment if they meet quality and cost benchmarks. Horizon is also offering incentives—a lower premium and no deductible—to consumers to choose to see physicians who are a part of a medical home.[21] Covered California already encourages plans to adopt this model in the Contract, but it could similarly offer plans a reduced fee for each beneficiary empaneled with a primary care provider within a medical home.

Bundled Payments

Bundled payments basically set a flat payment for all services for a specific episode of care. IHA has been implementing these payments for specific care episodes in California PPOs through a grant from the federal Agency for Health Research and Quality (AHRQ).[22] For example, the IHA efforts tested bundled payments for knee replacements, angioplasty with stents, and cardiac catheterization.[23] The payment model sets a budget for an episode of care beforehand, based on the cost of the care episode historically, and it sets a budget for all of the services for that procedure and recovery afterward. Providers accept risk for cost overruns with this payment structure, but they can also retain savings if their costs are less than the bundled payment.

---

[19] Agency for Healthcare Research and Quality. Retrieved from: http://pcmh.ahrq.gov/page/defining-pcmh

[20] Grumbach, K., Bodenheimer, T., Grundy, P. (2009). The Outcomes of Implementing Patient-Centered Medical Home Interventions: A Review of the Evidence on Quality, Access, and Cost from Recent Prospective Evaluation Studies. Patient-Centered Primary Care Collaborative. Retrieved from: http://pcmh.ahrq.gov/sites/default/files/attachments/The Outcomes of Implementing Patient-Centered Medical Home Interventions.pdf

[21] Reed Abelson (2014). Health Insurers are Trying New Payment Models, Study Shows. New York Times. Retrieved from: http://www.nytimes.com/2014/07/10/business/health-insurers-are-trying-new-payment-models-study-shows.html?_r=0

[22] Institute for Healthcare Quality (2014). Retrieved from: http://www.iha.org/bundled-payment.html

[23] Ibid.

Typically these payments work best for well-defined or more discrete episodes of care.[24] However, establishing the necessary contractual agreements among all of the providers involved in a specific episode of care can be difficult because the parties have to agree about how to divide the bundled payment among themselves.[25] RAND has evaluated the results of IHA's bundled payment initiative, and the results are forthcoming.[26] Pending the effects of these pilots, Covered California ought to collaborate with IHA to determine where it could motivate insurers and providers to use and further develop these arrangements.

Reference Pricing

Reference pricing is another consumer (or "demand-side") approach to steering individuals toward more efficient providers. Under this pricing structure, the insurer sets a reference price for a service or procedure, often in the middle of the range of prices that providers negotiate.[27] The insurer can establish a policy of paying the reference price for a certain procedure and requiring the consumer to pay the difference if they would like to see a particular provider with higher prices. Reference pricing programs tend to work best with larger provider networks, such that access to care would not suffer, and for fairly routine procedures that often have relatively low variation in quality (colonoscopies or knee arthroscopies, for example).[28] Covered California could similarly offer some positive financial incentives to plans to support the establishment of these programs, with the ultimate goal of reducing premiums (more detail about these incentives below.)

Creating Pay-for-Value Incentives in Covered California

To provide an incentive to adopt pay-for-value approaches, Covered California could offer plans the option to charge a slightly higher premium for the first plan year in which the insurer implements new value-based payment models. However, Covered California should also secure a commitment from those plans to achieve a specific level of savings in future plan years, with an associated commitment to lower premiums as well. In these negotiations, both Covered California and insurers ought to consider the impact that higher premiums may have on enrollment in these plans. Covered California should promote the added value that these plans offer so that consumers can weigh the both the quality benefits and premium costs of plans with value-based designs. Outreach, education, and enrollment resources, as well as quality reporting information, would be ways of making consumers aware of particular plans' efforts to increase value.

---

[24] Bertko, J. & Effros, R. (2010). Increase the Use of "Bundled" Payment Approaches. RAND Corporation. Retrieved from: http://www.rand.org/pubs/technical_reports/TR562z20/analysis-of-bundled-payment.html

[25] Robert Wood Johnson Foundation (2013). Bundled Payment: The Quest for Simplicity in Pricing and Tying Payment to Quality. Retrieved from: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf406415

[26] Integrated Healthcare Association (2013). Bundled Episode Payment & Gainsharing Demonstration – Dissemination Products. Retrieved from: http://iha.org/pdfs_documents/bundled_payment/IHA_AHRQ_Dissemination_Products.pdf

[27] Robinson, J.C., & MacPherson, K. (2012). Payers Test Reference Pricing and Centers of Excellence to Steer Patients to Low Price and High-Quality Providers. Health Affairs 31(9). Retrieved from: http://content.healthaffairs.org/content/31/9/2028.full

[28] Ibid.

Highlighting this information may offset some of the negative enrollment effects of the temporarily higher premiums that these plans may have.

Transparency, Data Collection, and an All-Payer Claims Database

Transparency is another important element of increasing value on behalf of consumers. In fact, the effectiveness of some of the concepts described above may hinge on the availability of comparable information about providers' prices and performance. Without a reliable source of information about plan and provider performance, consumers and employers cannot make meaningful choices based on quality and price.

Covered California has already established transparency as one of its core values, and it has invested a great deal of effort into developing provider quality ratings for participating plans.[29] One major hurdle for this project was the fact that many of the provider networks for participating plans were newly formed by insurers for Exchange health plans. Nevertheless, Covered California has already established many quality data submission requirements for plans (several outlined above), and it should leverage this information to inform quality incentives and requirements in its future plan contracts. Moreover, Covered California should distill and incorporate this data into its plan quality ratings for consumers in future plan years. With this information, consumers would be able to make more meaningful comparisons of what their premiums were paying for when selecting plans during open enrollment periods.

Additionally, a bill that would establish an All-Payer Claims Database (APCD) is stalled in the Senate Appropriations Committee. The APCD would give insurance companies, employers, and consumers key information about providers' costs, utilization, and quality. The 2012 Massachusetts health reform law created a similar entity that requires all healthcare provider systems to register with the state and to report financial performance, market share, cost, and quality data.[30] Covered California could use a statewide APCD to collect, analyze, compare, and disseminate much richer information about plans' networks.

With access to this information, purchasers of health care services would be able to make better decisions when negotiating with and assembling provider networks. In addition, consumers would have far more information about providers' performance. Since most Covered California plan enrollees have out-of-pocket cost-sharing responsibilities, consumers would be encouraged to seek the best value for their dollar.

Purchasing Coalitions

Covered California also ought to align with other purchasers to push the commercial insurance market as a whole to pay for value. By aligning with other payers, Covered California could maximize the effect of new payment models to benefit the greatest number of California's consumers. It is already a member of PBGH with other large purchasers of coverage, including CalPERS, the University of California system, Safeway, Target, Pacific Gas and Electric, Wells Fargo, and many others.[31] By further developing

---

[29] Covered California (2014). Covered California Consumers Can Now Use Quality Rating System When Choosing a Health Care Plan. Retrieved from: http://news.coveredca.com/2014/01/covered-california-consumers-can-now.html

[30] Connolly, op. cit.

[31] Pacific Business Group on Health (2014). Retrieved from: http://pbgh.org/about/members

strategies with these organizations and large employers, Covered California could gather expertise about successful value-based purchasing strategies and foster greater alignment among large purchasers. If a greater share of commercial payers in the market adopt value-based insurance designs, more providers will have a strong incentive to shift their behavior because their payment models will be more uniform. On the other hand, if a large share of payers continue FFS payment, providers will more easily be able to evade reforms that reward better care and controlling costs.

Covered California should also use and build its relationships with public payers to maximize the effect of pay-for-value strategies. Many providers have a diverse mix of payers, and purchasers of health services should seek the greatest possible effect when attempting to get better outcomes for their dollar. Moreover, supporting greater quality and cost control for all consumers and programs promotes equity, another major emphasis of Covered California.[32] Vulnerable groups who receive coverage from public programs should also benefit from improvements in value-based payments.

Covered California already has very strong relationships with the Medi-Cal program—a necessity given their adjacent program eligibility ranges, which create churn between the programs. Moreover, many families in California are split between the programs because children and adults have different eligibility levels for Medi-Cal.

While Covered California is in frequent contact with the federal Centers for Medicare and Medicaid Services (CMS) because it determines the federal guidelines for all states' Exchanges, Covered California administrators ought to very actively collaborate with CMS' Center for Medicare and Medicaid Innovation (CMMI), which implements and evaluates Medicare and Medicaid payment reform initiatives in California. Covered California's plan contract already lists two of CMMI's payment reform pilots, the Comprehensive Primary Care Initiative and Share Savings Program, as potential quality collaboratives for plans to join. The Contract also requires plans to report and provide for consumers data that reflects the CMS Hospital Compare Program and CMS Physician Quality Reporting System.[33] As Covered California assesses and reports both the participation in and the results of these pilots, as well as providers' performance on the CMS quality measures, it could have a meaningful effect on the alignment of provider incentives across payers. This goal should become increasingly central to the quality strategy over the next several years.

Looking Forward

Covered California has laid an excellent foundation for an ambitious and visionary quality strategy that may serve as a model for other states' Exchanges. In the coming years, it ought to build on these efforts to motivate its health plans to provide increasingly greater value for California's consumers. The initial success of Covered California and its potential to grow in the state's health insurance market could produce very positive, transformative effects. As an entity with the public interest at the core of its mission, it should ultimately expand the scope of its quality strategy so that it aligns with other public and private payers to increase quality and control costs across the entire health care system and all of California's health care consumers.

---

[32] Covered California website, op. cit.
[33] Covered California Qualified Health Plan Contract, op. cit.

Illuminating Health Care Prices: Organizations to Watch

October 8th, 2014 by *Emily Newhook* 0

http://publichealthonline.gwu.edu/healthcare-price-cost-transparency/

Health care costs have increased three times faster than wages over the past decade. Just like any marketplace, prices for medical procedures, equipment and treatments vary dramatically among providers. An appendectomy can cost anywhere from $1,529 to $186,990 . A hip replacement could run from $11,100 to $125,798 . But trying to determine the actual price you'll pay — or the one you should be paying — can be daunting for the average consumer. And once that pricing information is available, how can we aggregate and utilize it to make health care more affordable for everyone? Here, we've broken down the issue of health care price transparency and profiled fourteen exciting, effective and innovative organizations that support it in different ways.

> *"In 2014, we make purchasing decisions for every other commodity based on transparent price and quality information. Why not healthcare, too?" — Dr. Neel Shah, Costs of Care*

1. **American Board of Internal Medicine Foundation (ABIM) — Choosing Wisely**
2. **California Health Care Foundation (CHCF)**
3. **Castlight Health**
4. **Catalyst for Payment Reform**
5. **Clear Health Costs**
6. **Change Healthcare**
7. **Costs of Care**
8. **Council for Affordable Health Insurance (CAHI)**
9. **Emergency Care Research Institute (ECRI)**
10. **FAIR Health**
11. **Healthcare Bluebook**
12. **Health Care Cost Institute (HCCI)**
13. **Health Care Incentives Improvement Institute**
14. **Health Care Financial Management Association (HFMA) – Price Transparency Task Force**

Price Transparency: What's at Stake

Proponents of health care price transparency contend that publishing price information could both rein in the extraordinary range of costs people pay and lower the level of prices in general. This kind of price transparency empowers consumers to comparison shop for health care as they would a car, house or television, forcing higher priced providers to lower their prices to stay competitive.

Price transparency is at a crossroads as millions of previously uninsured Americans receive greater access to medical care under the Patient Protection and Affordable Care Act (ACA) . Many of these

people opted for one of the less expensive “bronze” or “silver” plans, which typically cover 60 to 70 percent of the costs of treatment. There’s no doubt this is a great improvement over not being insured at all. But, in the case of an appendectomy, a patient on a silver plan could be responsible for $458 or $56,000 depending on where the procedure takes place. Without access to meaningful price information, how would a patient know what to expect when the bill arrives?

There are many factors contributing to the variations in health care pricing. Some areas have higher operating expenses, such as in New York City versus North Dakota. Sometimes, the same medical procedure can be conducted in a different, more expensive way by using high-tech equipment or newer, more expensive drugs. Another reason for variations in price are provider or hospital markups, which have been shown to be exorbitant at times, marking up cotton swabs or routine X-rays by 400 percent.

“You get what you pay for” is not always true in these high-cost situations. There is little evidence supporting a relationship between higher health care costs and health care quality. More importantly, few people would know where to begin to access and assess price and quality indexes in order to make well-informed decisions. Frequently, consumers first see their bill when it arrives after the procedure, which may leave them feeling taken advantage of. This has the effect of eroding trust in the health care system as a whole.

Stalling the unprecedented growth of health care costs is thought to be essential to the long-term fiscal stability of the United States. This is thought to be so important, in fact, that over 30 states have passed or have proposed legislation to increase price transparency. A majority of state-run initiatives publish average or median prices for individual services, but many proponents of price transparency favor reporting of all amounts paid to every provider for every service so trends can be tracked with actual data. They also contend that this kind of reporting acts as a disincentive for backdoor deals that they contend contribute to escalating health costs in general.

Not surprisingly, insurance companies are some of the most vocal opponents of price transparency. Insurance companies negotiate prices with hospitals and providers largely in secret, allowing them to get better deals for their consumers. Insurance providers claim that their ability to pass these negotiated lower costs onto consumers would be compromised if they had to publish their negotiated rates to competitors. They also contend that hospitals may decide not to negotiate with them at all, leaving their customers with rising costs.

Some opponents of price transparency argue that aggregating the massive amount of data needed to keep price reporting accurate is difficult to collect and audit for accuracy. Others say that price transparency could actually raise the price of health care, and still others point out that releasing price information would be a hollow objective if it is not paired with quality outcome data — meaning the price data would have no real value. In the absence of value, it is possible that consumers might assume a $125,798 hip replacement is better than an $11,100 one, causing the provider of the $11,100 and others to raise prices to stay competitive (and make more money per procedure in the process).

Who’s Leading the Charge?

Many organizations and initiatives, however, are dedicated to achieving greater price transparency and decoding its complicating factors. Some of these organizations create resources that help providers have a frank discussion about prices with their patients. Some educate patients regarding the extreme variation in health care pricing and help them compare prices before pursuing a treatment plan. Others are dedicated to ensuring that data — once it has been made transparent — is accessible, contextualized and comprehensible. Read more about their efforts below.

American Board of Internal Medicine Foundation — Choosing Wisely

www.choosingwisely.org

Founded: 1999 (American Board of Internal Medicine Foundation)

Choosing Wisely is an initiative of the American Board of Internal Medicine Foundation (ABIM) that promotes open dialogue between providers and patients to choose treatment plans that are supported by evidence, not duplicative of other tests or procedures already received, free from harm, and truly necessary. “We’re more focused on appropriateness,” says Daniel Wolfson, Executive Vice President and COO of ABIM. “‘Is this test or procedure appropriate for this patient at this time?’”

Choosing Wisely also works to make sure that patients have a full view of the costs, both monetary and otherwise, associated with a care plan and to include costs as part of the discussion which crafts that patient’s care. The program asks medical providers to “choose wisely” the tests and procedures for each patient, even if they are widely used in their field.

“We do think it’s important for there to be awareness of what things cost and getting the information around cost, What’s really going to be important is how physicians have those conversations about what things cost.”

Part of the problem, Wolfson suggests, is the fact that physicians often feel responsible for determining appropriate or necessary care, but not for the cost of that care: “Keeping the patient engaged in their care is the responsibility of the physician. If it’s an affordability issue that is going to prevent treatment from happening, then there needs to be a discussion about that. I think providers need those skills.”

The Choosing Wisely initiative has been working with Consumer Reports Health to provide patients with better information about their options for care. It also partners with consumer groups and other professional medical associations to disseminate patient-friendly materials. The campaign has not been independently evaluated, but the common sense, patient-friendly approach has inspired replication in Canada by the Canadian Medical Association .

California Health Care Foundation

www.chcf.org

@CHCFNews

Founded: 1996

President and CEO: Sandra R. Hernández, M.D.

The California Health Care Foundation (CHCF) is a nonprofit that provides grants totaling around $35 million that improve clinical outcomes and quality of life for Californians with chronic disease. One of the foundation’s main goals is promoting greater transparency and accountability in the health care system. The foundation is a leading force behind price transparency at the state level in California, convening task forces and meetings to fine-tune policy.

As a leader in health care advocacy in California, the CHCF has been very influential in bringing health care cost transparency to the attention of influential Californians. In 2009, Maribeth Shannon, director of CHCF's Market and Policy Monitor program, testified as an expert before the California Assembly Committee on Health regarding transparency, quality data and outcomes in a testimony called "What Is Transparency in Health Care and Why Does It Matter?" In her testimony, Shannon stressed the importance of providing data that works for the consumer, stating, "Where quality is largely independent of what kind of coverage a patient has — though some may debate that — cost is very specific to an individual's insurance coverage, benefit design and financial situation. What is important here is to know not the average price but to know 'my price.'"

> *"What is important here is to know not the average price but to know 'my price.'" — Maribeth Shannon, California Health Care Foundation (CHCF)*

"There are really two problems," says Shannon, with regard to some of the bigger issues facing the transparency movement. "The first and most important is lack of data. In California, pricing data is largely unavailable. Sharing what *is* available – billed charge information, or average regional pricing – is just not helpful. People want information specific to their circumstances: to know what *they* will pay (given their plan design and the provider options available to them), not what some people charge. The second major problem is that up until very recently consumers did not research their health care options. Is that because there wasn't useful data? Partly. But it is also because many people are locked into networks – they go where their physician or health plan tells them to go."

Incentives, or lack thereof, can also contribute to whether or not people research their options. "Most people in California are still covered through HMO plans (though that is starting to change). If it costs you a fixed co-pay amount, regardless of where you go, there is no incentive to shop for a better deal. With the introduction of the Covered California program (Obamacare), there is some new movement toward higher deductible plans, so maybe the market is beginning to change and more people will be subject to deductibles – increasing their financial incentive to shop for 'best value.'"

More recent efforts, such as the 2013 briefing "Inside the Black Box: The Future of Price Transparency in California" addressed data collection issues, the ongoing need for price transparency, and the future.

Castlight Health

www.castlighthealth.com
@CastlightHealth
Founded: 2008 by Todd Park, Bryan Roberts and Giovanni Colella
CEO: Giovanni Colella

The founders of Castlight felt the tools being offered, primarily by health insurers, were opaque at best and set out to make something better. What makes the resulting tool not just better, but completely innovative, is that it offers both price information and quality metrics for tests and procedures in the same place. The tool is available to the employees of businesses who have subscribed to the service as a web application that aggregates cost data from the subscribers' insurance companies along with quality, usage and coverage metrics. The Castlight Health tool has an added benefit in that the subscribing business can use the data from the tool to adjust the benefits it offer its employees.

Catalyst for Payment Reform

www.catalyzepaymentreform.org
@CPR4healthcare
Founded: 2009 by a group of employers, including Pacific Business Group on Health
Executive Director: Suzanne F. Delbanco Ph.D.

Catalyst for Payment Reform (CPR) was created to work toward payment-model reforms and act as a catalyst for those reforms. CPR has a holistic approach to payment reform, from reporting on shortfalls in the current system to providing a solutions framework to establishing connections and collaborations to align efforts of different interests including policymakers. “At CPR, we like to say price transparency is one of the core building blocks of payment reform and a higher-value health care system,” says CPR Executive Director Suzanne Delbanco. “Purchasers and consumers need transparency for three primary reasons: (1) to help contain health care costs; (2) to inform consumers’ health care decisions as they assume greater financial responsibility; and, (3) to reduce unknown and unwarranted price variation in the system.”

“In some pockets of the country, we still have issues getting price data because health care providers and health plans use gag clauses in their contracts with each other to prohibit sharing information on paid amounts with consumers,” Delbanco continues. “But even where gag clauses do not exist, some consumers still can’t find meaningful price information. Some may be fortunate enough to have access to a price transparency tool provided by their health plan or employer. But some don’t. And very few states actually have laws that require health plans and health care providers to make this information available to consumers.”

One of the greatest accomplishments of CPR is the creation and dissemination of an innovativePayment Reform Toolkit . Geared towards employers’ evaluation of health plans during the decision-making process, the toolkit provides employers with model contract language to use when formalizing their expectation that health plans implement innovative payment models, delivery models and quality metrics. The toolkit provides an overall framework and map for nationwide payment reform and aligns some of the best in public and private sector strategies. The main components are guidance on market assessment, action briefs, aligned sourcing information, health plan user groups utilization, comprehensive specifications for the evaluation of transparency tools and an example how-to guide for implementing a bundled payment program for total joint replacement.

Clear Health Costs

www.clearhealthcosts.com
@chcosts
Founded: 2010
CEO: Jeanne Pinder

Clear Health Costs was started with a $20,000 grant from the CUNY Graduate school of Journalism and has gone on to be awarded grants by the International Women’s Media Foundation and the New Media Women Entrepreneurs project. Why are all of these prestigious institutions so excited? Clear Health Costs offers consumers pricing information for health-related procedures and treatments in seven U.S. metropolitan areas: New York, San Francisco, Los Angeles, Dallas-Fort Worth, Houston, San Antonio and Austin. The prices, listed as total cash price without insurance, offer a clear and easy way to compare prices at specific health care providers. The site gives provider names, contact information and addresses in order to make it easy to take advantage of the information provided.

“With the rise in high-deductible plans, higher co-insurance and more out-of-network, out-of-pocket spending, people are really interested in this right now,” says Clear Health Costs CEO and founder Jeanne Pinder.

> *“Increasingly, people are seeing the effects of our opaque marketplace in their checkbooks, and they’re horrified.” — Jeanne Pinder, Clear Health Costs*

The cost information on Clearhealthcosts.com comes from two different sources. The first is an interesting crowd-sourcing experiment. The second is the staff of Clear Health Costs, who are primarily investigative reporters. These two sources result in real-world pricing based on what actual patients are paying. For instance, a well woman exam at a New York City 5th Avenue gynecological office is $150, while one just a few blocks away at a Madison Avenue practice is $350.

“We are really enthusiastic about state governments and other organizations that have used the data they have to make consumer-friendly tools…[but] one drawback of some of these tools is that they’re limited to hospital claims,” says Pinder. “As you might suspect, we are partial to our pricing survey methodology: We collect cash or self-pay prices for common procedures that we regard as ‘shoppable’ from a comprehensive range of providers in seven U.S. metro areas. We juxtapose those cash or self-pay prices, reported by the providers themselves, with the Medicare paid rate — the closest thing to a fixed or benchmark price in this market.”

Pinder says that the discussion about rising costs was “present but muted” before the Affordable Care Act. Now, however, “people have brain space to look at the money, and they’re horrified. There’s a consumer dynamic awakening in this country around medical costs.”

Change Healthcare

www.changehealthcare.com

@ASKCH

Founded: 2007

President and CEO: Douglas Ghertner

Change Healthcare is a private company that seeks to change the way people purchase and use health care service by driving engagement on an individual level. It is the nation’s leading provider of health care cost information, with over 7 million users in all 50 states. The Change Healthcare tools are subscription based and can be accessed by individuals associated with an employer or insurer who is part of the program. The program uses quality, cost and convenience data to help individuals make health care decisions and manage their out-of-pocket costs while receiving high-quality care. Change Healthcare also has a program for employers, Healthcare University , that helps clients learn to take full advantage of available health benefits.

Change Healthcare President and CEO Douglas Ghertner says his direct interactions with consumers during his tenure at CVS/Caremark initially drew him to the Change Healthcare mission. “[At CVS], I had an opportunity to interact with a lot of our clients. People were regularly insulated from the cost. That caused me to start looking at the space differently. You see this overarching trend of consumerism in healthcare…and I think that trend will continue.”

Change Healthcare also recently began to publish quarterly reports of all medical claims of all Change Healthcare clients: Change Healthcare’s Healthcare Transparency Index (HCTI) . The HCTI provides a

comprehensive report of costs and cost variability of different health care services and includes a Transparency Matrix, which assigns health care services to high and low-cost categories.
Ghertner says consumers are more aware than ever before of what they're paying for health care costs. "Generally, there's an overarching familiarity with the importance of transparency. All of [these groups] are now talking about transparency, and that's a positive. The ACA in and of itself — it just highlights the need for these types of tools."

> *"It's not just all about price. It's about price and quality." – Douglas Ghertner, Change Healthcare*

Costs of Care

www.costsofcare.org
@CostsofCare
Founded: 2010 by Neel Shah, M.D.
Executive Director: Neel Shah, M.D.
"In 2014, we make purchasing decisions for every other commodity based on transparent price and quality information (think Yelp, Travelocity)," says Costs of Care Executive Director Neel Shah, M.D. "Why not healthcare, too?"
The question speaks directly to the Costs of Care mission, which Shah started while he was an OB-GYN resident with the aim of designing materials to help doctors-in-training learn to make clinical decisions that optimize care and cost. The organization brings together the best medical educators, practitioners and health care economists to collaborate on the materials, collectively called the Teaching Value Project .
The teaching modules are presented as part of the familiar ethical framework of "do no harm" and make learning to be conscious of patient costs a moral imperative for aspiring doctors and experienced practitioners alike.
To support the learning modules, Costs of Care is in the process of building decision-support tools, including a mobile application to help doctors take in all considerations during their clinical decision-making process. Vineet Arora says that funding from the ABIM Foundation, the organization has also been able to launch a Teaching Value and Choosing Wisely Challenge — which enters its second year later this fall– to "identify the most promising ways to incorporate teaching about value into medical education."
Shah says that the transparency movement has grown exponentially since he started Costs of Care in 2010. "What started as a cottage industry less than five years ago has become a booming movement to empower patients with information on the cost of care," he says. "The inflation and arbitrariness of healthcare pricing has dominated media stories from the cover of Time Magazine to a recurring series in the New York Times. The rapidly increasing focus on transparency has been partly catalyzed by growing numbers of price-sensitive patients on high deductible plans and partly driven by the way the internet has evolved."

Council for Affordable Health Insurance

www.cahi.org
Founded: 1992
Interim Executive Director: Marianne Eterno

The Council for Affordable Health Insurance (CAHI) is an association of insurance carriers that conducts research and advocacy to promote affordable insurance through market-oriented solutions. It works to advocate for health-reform measures that benefit all players in the American health care market through thorough evaluation and dissemination of analysis, positive or negative, of health care reform measures. Board members of the CAHI regularly advise Congress and state legislators and are often called to testify formally. The CAHI produces high-quality policy analysis and collaborates with an extensive network of other organizations to disseminate its message.

Emergency Care Research Institute

www.ecri.org
@ECRI_Institute
Founded: 1968
President and CEO: Jeffrey C. Lerner, Ph.D.
The Emergency Care Research Institute (ECRI Institute) is a nonprofit that has been bringing applied scientific research to health care for over 45 years. Its current mission is dedicated to discovering which medical procedures, devices, drugs and processes best enable improved patient care. ECRI Institute is a designated Evidence-Based Practice Center by the U.S. Agency for Healthcare Research and Quality and a federally certified Patient Safety Organization by the U.S. Department of Health and Human Resources.
Since 1996, the ECRI has published pricing information on single-use medical products from information provided by hospitals. This PriceGuide can be found online and is used by member hospitals to track costs. In 2007, the ECRI was involved in a landmark lawsuit against Guidant, a manufacturer of pacemakers who claimed that ECRI's publication of prices was not lawful. ECRI won the case by asserting that it is in the national interest to allow health care providers to engage in comparison-shopping.
Since 2012, the ECRI has been collaborating with Modern Healthcare to publish a Technology Price Index, which provides a snapshot of average prices paid by providers for 30 key capital and supply items based on data from ECRI Institute member facilities. This index is updated monthly and includes graphs for the top 10 supply items by total spending, the top 10 most expensive capital items and the top 10 most popular capital items. This index is aimed at helping health administrators keep tabs on the ups and downs of the industry.
ECRI Institute has other supports available for the general public and for health care providers alike including articles, policy statements and other resources.

FAIR Health

www.fairhealthconsumer.org
@FAIRhealth
Founded: 2009 as a result of action by New York State Attorney General
President: Robin Gelburd
"Not everyone has been a doctor, but everyone has been a patient," says FAIR Health President Robin Gelburd. She's worked in health care for more than 25 years.
In 2009, an investigation by the New York State Attorney General's office uncovered conflicts of interest within the Ingenix database that health insurers used to calculate reimbursement for patients who

received care from out-of-network providers. The resulting settlement allowed the insurers to not admit any wrongdoing in exchange for funding a new database to be run independent of the insurance industry. The result was the FAIR Health database.

> *"Not everyone has been a doctor, but everyone has been a patient." – Robin Gelburd, FAIR Health*

"It's like we're living in a laboratory in real-time," says Gelburd of the evolving transparency movement. "It's really been rewarding to see that there has been a change in the conversation. I think everyone recognizes that the train has now left the station. There are a variety of factors that are necessitating transparency to move forward…[and] narrowing tiered networks that require consumers to roll up their sleeves and determine what kind of care they want to receive."

"In the absence of transparency, there's a lot of legal static," she continues. "There's a lot of confusion and surprise bills, which really erode the relationship between patients and their employers, plan representatives and providers. It makes sense to arm consumers with good information."

But transparency, she says, is just the beginning of a much bigger undertaking. Even if more data about health care costs – think the recent releases from the Center for Medicare and Medicaid Services – becomes accessible, will the average consumer be able to make sense of it and use it to make educated decisions about their care?

"For us, transparency isn't even the catch word anymore. We see a huge difference between transparency and clarity…We try to not create a chaotic pile of data, but really contextualize the data and use language that is comprehensible that gives people a foundational understanding."

In addition to providing out-of-network reimbursement rates, FAIR Health also offers data products for research and policymaking in addition to providing patients with clear information regarding the reimbursement process through www.fairhealthconsumer.org .

Healthcare Bluebook

www.healthcarebluebook.com

@HCbluebook

Founded: 2008 by CareOperative, LLC

CEO: Jeffrey J. Rice, M.D., J.D.

Healthcare Bluebook founder and CEO Jeffrey Rice knows first-hand the extent to which prices can vary for a given procedure. When his son needed surgery, the first facility he queried wanted to charge his family $3,700. Upon further consultation with his son's physician, though, they were able to locate a nearby facility that was just as good – one that charged only $1,500.

> *"Patients need to understand that there is enormous price variation in health care. If you're going to buy a gallon of gas, it might be $3.85 at one pump and $3.10 at another. In health care, the equivalent is $4.00 to $20.00." — Dr. Jeffrey Rice, Healthcare Bluebook*

Healthcare Bluebook is a private enterprise that provides free online and mobile tools to help consumers find fair market cash prices for medical care. The website lists thousands of procedures, tests, medications and services and their fair market cash price by zip code. Healthcare Bluebook also allows consumers to view a "Fair Price" which is the amount that should be paid for a particular service. The Fair

Price is calculated by the amount that providers are paid for services, a price that is often lower than the provider's billed charges for a cash-payment patient.

Healthcare Bluebook also gives consumers the option to print a "binding price estimate" agreement based on the data that a patient can take to a health care provider to facilitate and empower patients negotiate fair rates for services. There are other unique tools on the website such as tools that group network providers into cost ranges for certain procedures and cost data presented against patient reviews and quality ratings from HealthGrades.com .

"When we started doing this, most patients definitely did not know that there were variations in pricing. Even large employers, five years ago, didn't understand what this opportunity represented," says Rice. But there's still plenty of work to do. "My company's job is to make sure that every patient gets the same care that I can get for my own family."

Health Care Cost Institute

www.healthcostinstitute.org

@HealthCostInst

Founded: Created in 2011 by Aetna, Humana, Kaiser Permanente and UnitedHealthcare

Executive Director: David Newman, Ph.D., J.D.

The Health Care Cost Institute — a research institute and data repository — tackles a different dimension of the transparency issue: Once we have what is truly an insurmountable amount of health care data, how do we organize it and make it accessible to experts capable of interpreting it?

The world has been, for the past two years, mesmerized with the concept of big data, and big data can be messy," says David Newman, Executive Director of the Health Care Cost Institute (HCCI). "It can be unwieldy, difficult to work with both from a structural perspective and in terms of having adequate resources from a machine perspective to deal with large data."

That challenge in mind, HCCI was created to design a database to give researchers and policymakers unprecedented access to health care cost utilization data including data that was previously inaccessible anywhere but the private insurance market.

> *"In order to improve the care people are getting, we need to improve the ability to bring [health care] data into one place." Dr. David Newman, Health Care Cost Institute (HCCI)*

HCCI is able to access this previously out-of-reach data because it is funded and created by top insurance providers. The sheer volume of data available in the HCCI database makes it unique among providers in this area. The database contains medical and pharmacy claims for 50 million Americans from all 50 states and the District of Columbia since the year 2007 and includes the actual amounts paid by both the insurers and the amount that came out of the patient's own pocket. The goal of this database is to promote research and policy that is based on better information as to what is driving the rising costs of health care.

"In order to improve the care people are getting, we need to improve the ability to bring all that data in one place," says Newman. "Our hope is that we assemble a large enough data set so that others can derive insights that are actionable."

The HCCI also releases annual reports available here .

Health Care Incentives Improvement Institute

www.hci3.org
@HCI3_org
Founded: Bridges to Excellence was founded in 2003, and later merged with PROMETHEUS Payment to form HCI3.
Executive Director: Francois de Brantes, M.S., M.B.A.
“We’re encouraged to see a shift in the conversation move from wishful thinking to part of the every day health care dialogue,”says Health Care Incentives Improvement Institute (HCI3) Executive Director Francois de Brantes. “Not only are we are seeing more demand from consumers for price transparency information, we are also seeing examples of it being put to use and reducing costs.” HCI3 is a nonprofit made up of physicians, employers, health plans and other stakeholders that work together to create programs that measure health outcomes, reduce care deficits and promote a team approach to caring for patients and realigning payment incentives to reflect quality and reward excellence.
“HCI3‘s mission is to improve the quality and affordability of health care. While there are various ways to do that, making medical prices public and actionable is a huge component,” de Brantes continues. This past March, HCI3 worked with Catalyst for Payment Reform (CPR) to release the second annualReport Card on State Price Transparency Laws . The results, says de Brantes, were “less than stellar”: 45 states failed and just two received a B for their efforts. Determining what consumers know, and what they need to learn, is another component to consider: “While there’s a huge opportunity as price transparency efforts take hold to better serve patients and drive down health care costs, many hurdles remain. One obstacle is to educate consumers that low price does not equal low quality, and visa versa.”
Understanding what quality means in relation to price is another challenge: to that end, HCI3 has also developed episodes of care definitions (called Evidence-informed Case Rates, or ECRs) which includePotentially Avoidable Complications , or PACs, to help incorporate the possibility of complications into consumers’ calculus when they shop around for prices: “In short, the higher the PAC rate a doctor has, the more likely you are to pay for extra services, such as corrective surgery or longer hospital stays.”
HCI3 also runs INQUIREhealthcare.org , which provides tools and resources to find high-quality doctors, sample questions to ask at appointments, and how to demand price transparency from their local providers and state legislators.

Health Care Financial Management Association — Price Transparency Task Force

www.hfma.org
Task Force Website: www.hfma.org
@hfmaorg
Founded: HFMA was founded in 1946 by William G. Follmer. The task force was founded in 2013.
CEO: Joseph J. Fifer, FHFMA, C.P.A.

The Health Care Financial Management Association (HFMA) is an organization that brings together stakeholders to identify gaps in the health care delivery system and then bridge those gaps through knowledge sharing and establishing best practices. The Price Transparency Task Force is made up of health providers, insurers and consumer groups such as Catalyst for Payment Reform. The task force is charged with crafting guidance as to how consumers can get clear, easy-to-understand information about health care costs before they undergo any procedures or treatment. The resulting report"Guiding Principles and Recommendations for Price Transparency" provides recommendations for how providers can ensure their patients have access to reliable health care cost information.

"The most significant factor that has changed the discussion on price transparency is the rapid growth in high-deductible health plans in both employer-sponsored insurance and plans offered on the exchanges," says James Landman, who is Director or Healthcare Finance Policy, Perspectives and Analysis at HFMA. "Consumers are responsible for more of the health care dollar than before, and their interest in—and need for—price information has grown accordingly. Employers, who are working to manage the cost of providing health insurance to their employees, are also very interested in tools that can direct employees to higher value providers—those that offer quality outcomes at a competitive price."

The task force also had the forward thinking to recognize that price transparency could have unintended consequences such as impacts on price negotiations within the business-to-business marketplace. The task force also recognized that the best solution for price transparency may not be a one-size-fits-all model. It recommended different networks for different patient groups such as insured patients, uninsured and out-of-network patients, employers and referring clinicians. This makes the task force's approach one of the most tailored in the industry.

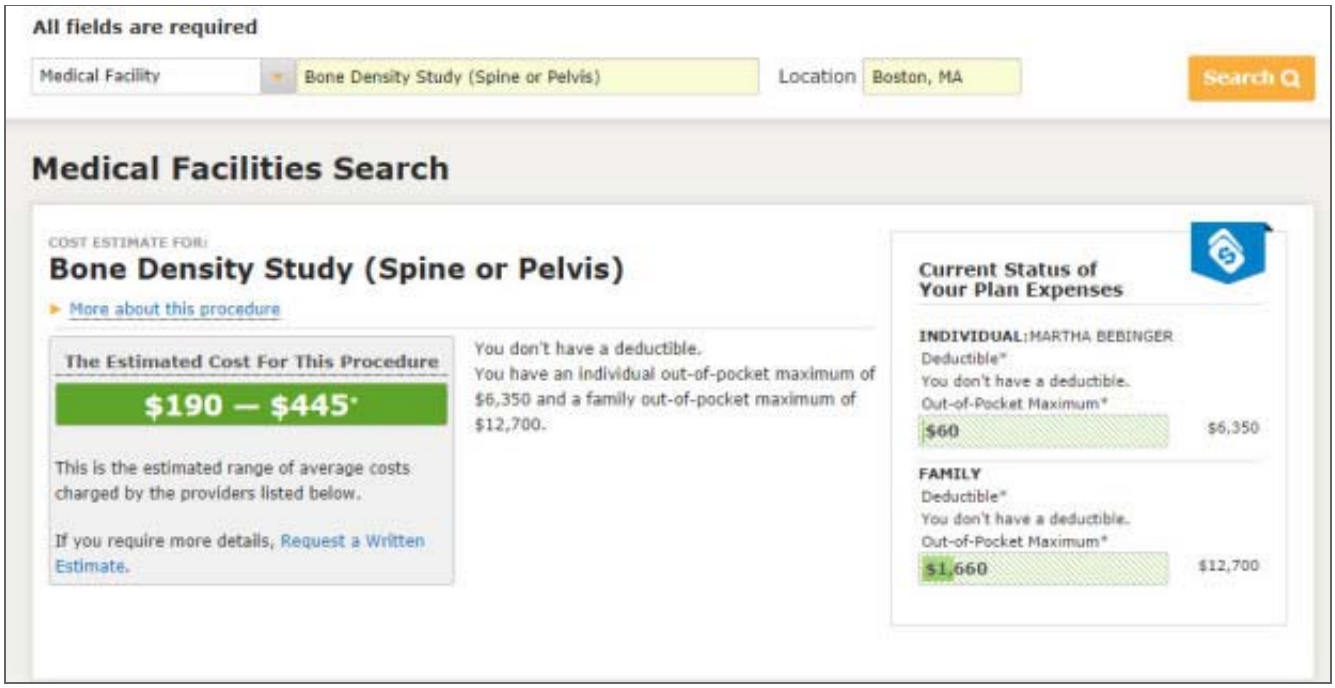
> *"Consumers are responsible for more of the health care dollar than before, and their interest in—and need for—price information has grown accordingly." – James Landman, Health Care Financial Management Association (HFMA)*

Moving Forward

Regardless of your position on price transparency, there is no doubt that these tools and resources are powerful and, if used wisely, can educate consumers and contribute to our nation's ongoing fight to control health care costs while improving overall health and wellness. Some of our nation's best and brightest are involved in these ventures, and their combined efforts are sure to make a lasting impact on how we manage our health care costs going forward

CommonHealth

Mass. Becomes First State To Require Price Tags For Health Care



CLICK TO ENLARGE: Massachusetts residents can now shop for their health care online, seeing prices for procedures and visits. (screenshot)

Massachusetts has launched a new era of shopping. It began last week. Did you notice?

Right this minute, if you have private health insurance, you can go to your health insurer's website and find the price of everything from an office visit to an MRI to a Cesarean section. For the first time, health care prices are public.

It's a seismic event. Ten years ago, I filed Freedom of Information Act requests to get cost information — nothing. Occasionally over the years, I'd receive manila envelopes with no return address, or secure .zip files with pricing spreadsheets from one hospital or another.

Then two years ago Massachusetts **passed a law** that pushed health insurers and hospitals to start making this once-vigorously guarded information more public. Now as of Oct. 1, Massachusetts is the first state to require that insurers offer real-time prices.

“This is a very big deal,” said Undersecretary for Consumer Affairs and Business Regulation Barbara Anthony. “Let the light shine in on health care prices.”

There are caveats.

1.) **Prices are not standard**, they vary from one insurer to the next. I shopped for a bone density test. The low price was $16 at Tufts Health Plan, $87 on the Harvard-Pilgrim Health Care site and $190 at Blue Cross Blue Shield of Massachusetts. Why? Insurers negotiate their own rates with physicians and hospitals. And some of the prices include all charges related to your test, others don’t (see No. 2).

2.) **Posted prices may or may not include all charges**, for example the cost of reading a test or a facility fee. Each insurer is defining “price” as they see fit. Read the fine print.

3.) **Prices seem to change frequently.** The first time I shopped for a bone density test at Blue Cross, the low price was $120. Five days later it had gone up to $190.

4.) **There is no standard list of priced tests and procedures.** I found the price of an MRI for the upper back through Harvard Pilgrim’s Now iKnow tool. That test is “not found” through the Blue Cross “Find a Doc” tool.

5.) **The quality information is weak**. Most of what you’ll see are patient satisfaction scores. There is little hard data about where you’ll get better care. This is not necessarily the insurer’s fault, for many tests the data doesn’t exist.

6.) **There are very few prices for inpatient care**, for surgery or an illness that would keep you in the hospital overnight. Most of the prices you’ll find are for outpatient care.

These tools are not perfect, but Tufts Health Plan Director of Commercial Product Strategy Athelstan Bellerand said “they are a major step in the right direction.” Bellerand added: “They will help patients become more informed consumers of health care.”

Patients do finally have a sense of how much a test or procedure will cost in advance. They can see that some doctors and hospitals are a lot more expensive than others. For me, a bone density test would cost $190 at Harvard Vanguard and $445 at Brigham and Women’s Hospital.

The most frequent early users are probably providers. Anthony says some of the more expensive physicians and hospitals react with, “I don’t want to be the highest priced provider on your website. I thought I was lower than my competitors.”

Anthony is hoping that response to this will generate more competition and drive down prices.

“I’m just talking about sensible rational pricing, which health prices are anything but,” she added.

Take, for example, the cost of an upper back MRI.

“The **range here is $614 to $1,800**, so three times,” said Sue Amsel, searching “Now I Know,” the tool she manages at Harvard Pilgrim. “That to me is a very big range,” Amsel said.

In this case, the most expensive MRI is at Boston Children's Hospital and the lowest cost option is at New England Baptist, with no apparent difference in quality.

"It's not just for choosing. It's primarily for getting you the information, about whatever you're having done, so you can plan for it," she said.

Most of us don't have to plan for anything except our co-pay. But about 15 percent of commercial insurance plans have high deductible plans, where patients pay the full cost of an office visit or test up to the amount of their deductible, and that number is growing.

"As more and more members are faced with greater and greater cost share, this sort of information is really important," said Bill Gerlach, director of member decision support at Blue Cross.

To use these tools, you'll log in on your insurer's website. If you have a high deductible, the online calculator shows how much you've spent so far this year toward your deductible. If your coverage does not include a deductible, the tool will calculate the balance towards your out of pocket maximum.

All these numbers are confusing. Most of us haven't thought about shopping for health care or paid attention to how much we spend. The state and most of the insurers are rolling out education campaigns to help us wrestle with the previously hidden world of health care prices.

One last tip: Look for the Blue Cross cost calculator under "**Find a Doctor**." It's not as easy to find as Tufts' "**Empower Me**" page or Harvard Pilgrim's "Now iKnow."

Both Tufts and Harvard Pilgrim used **Castlight Health** to build and now run their shopping tools while Blue Cross contracted with **Vitals**.

Aetna was the first insurer in Massachusetts to offer cost and quality comparisons through its **Member Payment Estimator**. It's not clear if all insurers doing business in the Bay State met the Oct. 1 deadline, but all of the major players did. There is no penalty for those who failed to do so.

We have a challenge for anyone who is ready to shop. Find the biggest gap between the high and low price for a test, treatment of procedure. You can measure the percentage gap or the total difference in price. Happy shopping!