

Health Care Solutions from America's Business Community: The Path Forward for U.S. Health Reform

*A Report from the
U.S. Chamber Of Commerce's
Health Care Solutions Council*

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**LABOR, IMMIGRATION &
EMPLOYEE BENEFITS DIVISION**

U.S. CHAMBER OF COMMERCE

FOREWORD

The U.S. Chamber of Commerce wishes to acknowledge many experts who contributed to the report. We would particularly like to thank Dr. Mark McClellan of the Brookings Institution for facilitating the Council's meetings and issue discussions, assisting with the engagement of other experts in the Council's process, preliminary drafting of most sections of the report, and other contributions. He received excellent assistance and support from Christine Dang-Vu.

We would also like to thank the many other experts who provided valuable perspectives on health care reform for the Council's deliberations. They are listed in Appendix B. The ideas and views in the report reflect those on which the Council reached consensus, and not necessarily those of the experts.

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EXECUTIVE SUMMARY

Our country's health care system has many strengths: tremendous medical innovation, cutting edge technology and drugs, and world-leading medical institutions. Nevertheless, there is tremendous variation in quality, cost and access to care as well as a growing burden of preventable chronic diseases. Three years after the enactment of the Patient Protection and Affordable Care Act ("PPACA"), further reforms are needed to achieve lower costs, innovative and high-quality care, and better health for Americans. America's employers are implementing many innovative reforms in health care and health promotion. This report describes how to build on those reforms to achieve innovative, sustainable, high-value care for all Americans.

Background

One year ago, the U.S. Chamber of Commerce convened a council of diverse member companies from major sectors of our health care system, including purchasers, suppliers, and deliverers of care. This council includes hospitals, insurers, pharmaceutical companies, medical device companies, large corporations -- such as manufacturers and international hospitality organizations -- and small businesses. When this "Health Care Solutions Council" began its efforts, the legal landscape and the future of the PPACA was uncertain. The constitutionality of the law was pending before the Supreme Court and congressional and presidential elections were on the horizon, all of which could have significantly affected the law's tenure and implementation. Following the Supreme Court's June 28, 2012 decision and the country's November 6, 2012 elections, the dust settled and implementation of the PPACA moved forward.

With the letter of the law intact, but much uncertainty remaining due to vagaries in the statutory language and regulatory process, the Chamber's Health Care Solutions Council ("Solutions Council") developed this report to propose additional reforms to address variation and disparity in access, cost and quality, and ease the law's burden on business and the public in the coming months. The Solutions Council's efforts represent the Chamber's recognition that:

- Critical further steps are needed to successfully address the nation's fundamental challenges related to health care delivery and insurance reform, and
- The business community must play a vital role in identifying and taking these additional steps collaboratively, recognizing that the employer-based system has worked well and should be maintained.

These efforts were driven by the Solutions Council's mission:

To achieve greater value in health care, as measured by more affordable coverage options and greater access to higher-quality, prevention-oriented care, leading to better population health and sustainable U.S. health care costs. By prioritizing efforts to improve the employer-sponsored health system which covers millions of Americans, we will use these solutions to drive system-wide changes.

The Solutions Council members listed at the conclusion of the report all contributed extensively to the report's development and they arrived at consensus on the vast majority of issues. Although not every member agrees completely with every recommendation, they all fully support the need for action now to address the issues described in the report.

The Solution

How can we address the tremendous disparity in the quality of care available, and the often inexplicable variation in the cost of and access to care? Simply put, the emphasis must be on increasing value within the health care system -- an analysis which must include both controlling cost *and* improving quality. While an honest discussion of this area must recognize that resources are not infinite, merely focusing on cost control as a type of "Holy Grail" is not the solution for a sector such as health care. After all, what is more important and worthy of resources than improving health, treating disease, extending life expectancy, and improving the quality of life? The focus must be on how we transition the health care system towards using the appropriate resources for the best possible outcome for each individual and evidence-based actions to drive population based health improvements.

As we examine both cost and quality to move towards greater value, changing how we pay for health care services and improving the nation's overall health will be critical in achieving the necessary reforms. Much has been said about the need to move away from a payment system where hospitals and doctors are paid based on the number of services they provide to a system that pays for the quality of the care rendered. The importance of both individual-based and population-based prevention, chronic disease management, and better coordination in the delivery of care across providers to improve the overall treatment of the patient is also well recognized. However, despite evidence that these employer-led approaches are achieving results in the private sector, national adoption and progress seems slow. The critical question is: can we make much faster progress toward these goals?

As an organization committed to private sector entrepreneurship and innovation, the Chamber and its Solutions Council recommend leveraging the successes in the employer-sponsored health care system. There are also changes that will be necessary – both regulatory and legislative – to build on these private sector advances in improving value. These recommended changes would:

- Facilitate and reward better communication among all providers – nurses, hospitals, specialists, and primary care doctors;
- Advance efforts to define quality simply and clearly so that providers understand the metrics by which they will be measured;
- Remove barriers to easily understandable and comparable information on the cost and quality of health care services;
- Encourage consumers to use this information to make health care decisions based on careful consideration of the expense and the likely outcome;

- Protect the ability to buy (or offer) affordable health care coverage that promotes higher-value care in the near term; and
- Apply the lessons of these private sector reforms to improve Medicare and Medicaid by:
 - Providing better care to the rapidly growing beneficiary populations served by these entitlement programs; and
 - Reinforcing innovations in the employer-sponsored system.

Specific Principles and Proposals

These broad themes are interwoven throughout the report in four distinct, but interrelated sections. The first two sections focus on private sector initiatives that advance meaningful transparency and greater value in health care. The second two sections address what changes are necessary to ensure these initiatives can continue in the private sector and be advanced in the Medicare and Medicaid programs.

Achieving Meaningful Transparency

Employers and insurance carriers provide various tools to their employees and enrollees to help them assess the cost and quality of providers and procedures and make the best possible medical decisions. In addition to highlighting these resources, the Solutions Council commits to promoting the use of consistent quality measures as part of payment contracts and urges the federal government to contribute summary Medicare data to enable the construction of accurate and comprehensive quality measures. In particular, the Solutions Council proposes to:

- ***Provide better, more consistent information on the quality of care;***
- ***Promote best practices for health plans to provide comparative information on the cost of care; and***
- ***Help consumers obtain consistent quality and costs when assessing coverage options.***

Realizing Greater Value in Health Care

Employers have crafted workplace wellness programs, disease management and care coordination initiatives, value-based insurance incentives, and health information technology resources to improve the health of their employees. This report includes specific examples of these efforts and proposes ways to build on these programs that improve health while rewarding providers for better results. In particular, the Solutions Council proposes to:

- ***Promote outcomes-based health care payment and benefit reforms;***
- ***Move toward outcomes-based regulatory reform; and***
- ***Advance the adoption of interoperable health IT systems nationwide.***

Supporting Effective Employer-Sponsored Coverage and Private Insurance Offerings

Ideally, the health reform law would reinforce employers' innovation and commitment to providing high-value coverage. However, there are several areas where its implementation may jeopardize some of the private sector advances. As we strive to expand health care coverage in the coming months through a variety of public and private mechanisms, several modifications to the health reform law will be necessary to ensure smooth implementation and to preserve the private sector initiatives that have improved value and curtailed unnecessary spending. In addition to highlighting examples of private sector practices, the Solutions Council offers recommendations on how to:

- ***Track implementation and assess the impact on premiums and access starting now;***
- ***Phase-in insurance market reforms;***
- ***Limit adverse selection;***
- ***Support high-value, prevention-focused coverage via regulatory actions and legislation if necessary;***
- ***Encourage greater employment; and***
- ***Enact further legislation to make health insurance exchanges sustainable.***

Reforming Medicare and Medicaid to Support Greater Value

Although the bulk of the report focuses on the policy reforms that directly affect the ability of business to obtain and provide high-value, efficient health coverage and care for their employees, the report also proposes ways to strengthen entitlement programs. Primarily, the recommendations consist of allowing some of the successful private sector initiatives to be adopted by Medicare and Medicaid. The Solutions Council offers recommendations on how to:

- ***Align Medicare with employer-sponsored and exchange coverage, by permitting competition among coverage options;***
- ***Implement further provider payment reforms in traditional Medicare to reinforce the care and delivery innovations supported by the private sector;***
- ***Reforms in Medicare benefit and Medigap should enable beneficiaries to save through higher-value choices and wellness activities;***
- ***Enable Medicare to support private-sector innovations in care;***
- ***Integrate Medicare and Medicaid coverage for dual-eligible beneficiaries;***
- ***Eliminate reliance on last-minute price reductions for Medicare providers, treatments, and Medicare Advantage ("MA") plans;***
- ***Consider implementation of additional Medicare financing reforms to help improve Medicare sustainability;***
- ***Encourage greater continuity between Medicaid, the exchanges, and employer-sponsored coverage;***
- ***Support greater care coordination and address preventable costs for high-cost/high-risk Medicaid beneficiaries;***

- *Continue Medicaid Disproportionate Share Hospital (“Medicaid DSH”) payments in states that do not expand Medicaid coverage; and*
- *Support multi-payer initiatives to improve care and lower costs.*

Conclusion

While the Chamber opposed the health reform law during the legislative debate, we offer this report to ease implementation, to avoid unnecessary costs and cost growth, and to protect and improve the private sector coverage that millions of Americans have long valued.¹ We believe the strength of these recommendations arises from both the substantive content and the fact that a very wide range of employers, who are often seen as having diverging interests, have come together to support these proposals.

Consistent with the Chamber’s general mission, we are also committed to a health care system based on “individual freedom, incentive, initiative, opportunity and responsibility.”² To achieve this, we will advocate the proposals and principles discussed in this report to advance: meaningful transparency of health care quality and cost information; greater value in the health care system; effective employer-sponsored and private health care coverage; and Medicare and Medicaid reforms to support greater value. The Chamber and the Solutions Council believe that leveraging the private sector initiatives currently underway and modifying the PPACA to mitigate the disruption to the private insurance markets, and employer coverage in particular, will help avoid instability and achieve greater value in health care during this implementation phase and as the nation tackles future health reform challenges.

¹ The Chamber opposed the health reform law during the legislative debate for: failing to control unnecessary costs growth; imposing costly burdensome requirements on employers and limiting the ability of consumers to purchase the type of coverage they want, need and could afford.

² The mission of the U.S. Chamber of Commerce is to advance human progress through an economic, political and social system based on individual freedom, incentive, initiative, opportunity, and responsibility.

INTRODUCTION

This is a critical time for health reform. In the coming months, many significant steps must occur to implement the coverage expansions and insurance reforms of the Patient Protection and Affordable Care Act (“PPACA”). For example, new regulatory requirements for most private health insurance coverage must be finalized and met in a very limited time frame. New systems to transmit key data must be established by the federal government, states, and the private sector to determine eligibility, payments, and penalties. Affected individuals and businesses need accurate and timely information to help them make decisions about these new requirements and programs.

At the same time, concerns about budget deficits and federal and state fiscal outlooks must be addressed to keep the nation’s economic growth secure. Even with the recent slowdown in some aspects of health care spending growth, far more needs to be done to ensure that the nation will continue on a sustainable fiscal trajectory in the years ahead. Given the disproportionate past and projected contributions of federal and state health care programs to these fiscal challenges, it is essential to chart an effective path for lowering health care spending that includes entitlement reform.

Health reform implementation and the nation’s fiscal challenges must be addressed in a way that supports the unprecedented opportunities for innovation to improve our health, our lives, and our country. Far more personalized and effective treatments can leverage genomic and other biomedical sciences, progress in information technology and data systems, and innovations in how and where health care is delivered. These advances all hold tremendous promise in preventing complications, improving care, and avoiding many of the costs in today’s health care systems. Supporting innovation in health care is also critical from the standpoint of the nation’s economic growth: some of America’s greatest potential to improve the well-being of the world’s citizens involves our leadership in biomedicine and innovative health care delivery.

Employers have and continue to demonstrate that many of the best opportunities to improve health require doing even more than promoting high-value, personalized health care. The biggest impacts on the health of the population come from behavioral, lifestyle, and environmental factors. While these broader influences are hard to change, there is increasing evidence that engaging individuals, families, communities, and businesses in promoting health and preventing complications can make a difference. In fact, many of the most innovative approaches include employer led strategies that go beyond the traditional delivery of health care, but which implementation of new PPACA requirements may jeopardize.

For these reasons, the U.S. Chamber of Commerce has convened the Health Care Solutions Council (“Solutions Council”). The Solutions Council represents a broad base of the Chamber’s membership, ranging from small businesses to large global corporations, and including a wide array of sectors such as: biomedicine, health sectors, telecommunications, manufacturing and technology, grocers, hospitality and restaurants

(See Appendix A). The Solutions Council's efforts represent the Chamber's recognition that:

- Critical further steps are needed to succeed in addressing the nation's fundamental challenges related to health care and health policy, and
- The business community must play a vital role in identifying and taking these additional steps collaboratively.

For nearly a year, the Solutions Council has worked steadily to develop a vision of effective health reform and has identified a set of key policy steps for achieving the vision. This report and its proposed solutions are driven by the Solutions Council's mission:

To achieve greater value in health care, as measured by more affordable coverage options and greater access to higher-quality, prevention-oriented care, leading to better population health and sustainable U.S. health care costs. By prioritizing efforts to improve the employer-sponsored health system which covers millions of Americans, we will advance these solutions to drive system-wide changes.

The Solutions Council's recommendations focus particularly on ways in which the business community can continue to advance meaningful health reform by building on the actions that Chamber members are taking now, as well as their first-hand experiences with the most significant implementation challenges. This is not simply a list of requests for others to act; it is a commitment by the Chamber and its members to work to improve the health care system.

All the employers on the Solutions Council are firmly committed to improving the value of health care coverage and services. In fact, every member has major initiatives underway within their organization, and often their community, to improve health and avoid unnecessary health care costs. These private sector initiatives highlight both the feasibility of realizing greater value in health care, and also the need for more rapid progress. We believe that it is possible for our health system to become increasingly vibrant and innovative in keeping Americans well, in addition to meeting their needs when people are not. Such a system should give employees reliable, understandable, and affordable choices for coverage – through their jobs, individual insurance markets, and other innovative private insurance arrangements. It should provide access to high-quality providers who receive much better financial support to deliver the best prevention-oriented care at the lowest cost.

The Solutions Council's recommendations include further administrative and legislative modifications as the health reform law's provisions move from the pages of legislation into final regulations. Without these modifications, analyses by the Solutions Council and many others show that the law will have significant adverse consequences for employers and employees alike. While these negative consequences are avoidable, there are specific steps that must be taken now to limit these problems if we are to achieve the law's goal of affordable, secure, high-quality health care coverage. With these steps, the Solutions

Council believes that employers can continue to have a major role in leading the way to affordable, innovative coverage and in improving health care to achieve much greater value for all Americans.

The Solutions Council's recommendations include reform proposals for improving Medicare and Medicaid that would allow these public entitlement programs to more effectively support and leverage employer-led reforms and initiatives. It is undeniable that these public programs have significant indirect effects on the private employer-sponsored system and that only by better aligning these payment and delivery systems can we achieve better value in health care for the country's population at large and truly tackle our budget and fiscal deficit issues. Therefore, the Solutions Council also proposes important modifications to the current landscape to facilitate widespread adoption of these private sector initiatives within the context of the Medicare and Medicaid.

Through these recommendations highlighting private sector innovations and identifying specific principles and proposals, the Solutions Council supports urgent public and private action on reform to advance: meaningful transparency of health care value; greater efficiencies in health care; employer and private health insurance reform; and entitlement reform. We recognize the challenges ahead and appreciate the experts that shared their views and knowledge with the Solutions Council over the past 12 months (see Appendix B). The Solutions Council members listed at the conclusion of the report all contributed extensively to the report's development and they arrived at consensus on the vast majority of issues. Although not every member agrees completely with every recommendation, they all fully support the need for action now to address the issues described in the report.

I. ACHIEVING MEANINGFUL TRANSPARENCY: BETTER INFORMATION ABOUT THE QUALITY AND COST OF HEALTH CARE

a. Background

Employers have long advocated for better information about the quality and cost of health care. While information alone will not improve health care value and reduce costs, it is necessary for both providers and health plans to improve quality. Employers and consumers also need better, comparable information on their choices to be effective purchasers of health care. Access to better information will foster more effective competition based on value, which will in turn drive improvements in care. Enhanced information would facilitate most of the Solutions Council's reform proposals and would also provide additional clarity as to which reforms are, and are not, working.

Employers are already driving important improvements towards greater transparency. By working with health plans, purchasing collaboratives, and a range of other innovative companies and partners, many employers are currently making information available about the quality and cost of care. Nonetheless, major gaps still remain between the information that could be available to people when they are making decisions about their care and their coverage, and the information that is available now. Our proposals are intended to rapidly close the transparency gap by building on these private sector initiatives and addressing the obstacles to effective transparency that have been identified. To help ensure progress, Chamber employers are committing to taking new steps to make more consistent information readily available. However, the federal government will need to take further steps as well for system-wide change to occur.

b. Private Sector Leadership

Many employers and employer coalitions have led the way in developing and implementing meaningful measures of quality and cost of care, a necessary foundation to improve transparency. They are helping their employees use this information to obtain more value in their insurance coverage decisions and investments related to personal health and well-being.

At *Boeing*, the company works with their providers to increase the availability of information regarding cost and quality on more than 150 common and important medical procedures. Over time, Boeing has been able to improve data accuracy and better predict the cost for a procedure by combining more data. By using mobile tools such as wireless applications, their employees can quickly look up lower cost prescription drugs and discuss these options with their health care provider. The company has also used performance data to help identify effective providers and encourage their employees to seek treatment from these individuals rather than providers who routinely recommend more costly procedures without commensurate benefits.

Dow Chemical (“Dow”) provides a tool for price and quality transparency that allows members to find the costs for procedures, doctor’s office visits, and lab tests. The tool also compares the costs of different doctors and hospitals to encourage members to look for savings. This cost of care tool uses members’ own plan details and factors in their plan’s deductible and coinsurance. Dow has worked closely with another partner (Truven), as well as community physicians, to create a Provider Performance Assessment (“PPA”) which evaluates physicians on both clinical effectiveness (quality) and cost efficiency (cost) dimensions, using the National Quality Forum (“NQF”) standards.

To support efforts by employers, many health insurance plans have developed valuable resources to help consumers access more comprehensive information on the quality and cost of health care, as discussed below.

Aetna offers a number of tools to help their members make informed decisions about the quality and cost of their health care. For example, their cost tools include a Member Payment Estimator that provides real-time, personalized out-of-pocket estimates for the most common medical, non-emergency, in-network health care services, including those that may offer the biggest opportunity to save on health care expenses and are likely to cause members to comparison shop. Aetna also has an Estimate the Cost of Care tool that provides members an estimate of the average in-network versus out-of-network cost of an episode of care, or overall average cost for certain diseases and conditions, for approximately 200 types of office visits, diagnostic tests and vaccines, surgical and scope procedures, dental services, and diseases and conditions. The Medical Procedure Costs by Facility tool allows members to review and compare cost ranges for medical procedures among participating facilities: inpatient, outpatient and other facilities (e.g., free-standing radiology centers). It also provides the following information: all costs from admission to discharge, facility-specific information – not regional averages – for over 30 common medical procedures (e.g., maternity care, MRIs, CT scans, colonoscopies, and mammograms). Displayed costs are broken down into managing physician charges and ancillary charges, as well as cost ranges. Additionally, the Hospital Comparison tool includes data on approximately 6,000 hospitals for 157 procedures, conditions, and diagnoses. In sum, all of these tools promote transparency to help members make better decisions about their care and their finances.

Health Care Service Corporation (“HCSC”) uses a Member Liability Estimator (“MLE”) tool to provide members with the information needed to make informed and intelligent decisions when it comes to researching treatment options and calculating personal financial responsibility. This application allows members to search the most common elective inpatient, outpatient, imaging services by facility, as well as the most common physician office visits. All costs are displayed at the episodic level (i.e., all cost rendered for a normal, uncomplicated procedure), including everything from admission through discharge. These costs are the insurer’s contracted allowed amounts and are shown in a narrow range

from minimum, to likely, to maximum costs. The likely amount is displayed as equaling the employer share (if the member is part of a self-insured plan) and the out-of-pocket amount. This “out-of-pocket amount” is further broken out by co-pay, coinsurance, etc., and each line item has context to educate the member on what these amounts mean and how each amount is calculated. Members are also presented with alternative treatment options depending on the procedure of interest and the available options.

UnitedHealth Group (“UHG”) has many resources available to help their members to make informed decisions. Their Health Care Cost Estimator (“HCCE”) tool provides consumers with a view of how treatment costs differ from doctor to doctor, in addition to delivering personalized cost estimates for various treatment options. The HCCE is an online resource that supports the evaluation of specific care, quality, and cost estimates for providers and facilities whether in the commercial, Medicare, or Medicaid market. The HCCE uses historical data from the entire UHG benefits data set. The data supports more reliable cost information for a specific service provided by a specific doctor or hospital – the level of detail that most consumers are looking for. The HCCE integrates provider quality data from national evidence-based guidelines for quality with local market benchmarks for cost efficiency. Empowering consumers with this information allows them to be more confident about the quality of their care, as well as be in control of the economics surrounding it. UHG also has a valuable, personalized, analytical resource called the Health Plan Manager that suggests opportunities for future cost savings and better care. It includes an innovative and intelligent user interface enabling flexibility to segment data by dozens of attributes customized to particular beneficiaries. UHG’s UnitedHealth Premium Physician Designation Program also helps members to make physician selection choices based on quality and cost efficiency.

As these examples illustrate, employers and health plans are actively striving to help employees access the information they need to make the best possible medical decisions to achieve the best value and health outcome. These efforts, however, could be much more effective with greater availability of meaningful information, more consistent use of measures that reflect the priorities of consumers, and greater reliance on these measures in payment and regulation.

c. Principles and Proposals

To enable consumers to assess the value of various health care services, providers and coverage options, several principle goals need to be advanced:

First, because individual employers and health plans often do not have sufficient data independently, greater collaboration is necessary to compile relevant, statistically valid information on quality of care available. Second, cost and quality measures need to be both relatively simple for providers to use and also relatively easy for consumers to understand. Cost measures should focus on final payments (premiums and out-of-pocket

costs) because these are the net costs that are actually paid for a service. The information should contain plan-specific cost measures when the consumer is making decisions about their care. However, when consumers and employers are making decisions for plan choice, they are also likely to need quality and total cost measures that are relevant to their needs and comparable across plans.

For example, consider the decisions facing an individual undergoing surgery for knee replacement. Patients should have access to information on the quality of the surgeon or surgical group and the hospital for important measures such as the providers' use of best medical practices, safety, complication rates, patients' experience with care, and functional outcomes like returning to work and full activity. Patients and their surgeons should also be able to obtain reliable quality information on which particular knee replacement devices available lead to better or worse outcomes. They should also be able to consider information about the impact of alternative post-operative rehabilitation programs and accurate estimates of the total out-of-pocket costs for the entire episode of care. In turn, employers and health plans should be able to determine both the expected quality and total costs of these different treatment options, so that they can make well-informed decisions about coverage and benefit design. Finally, when employees are choosing among health plans, they should be able to compare both premiums and quality of care across a range of these important areas of care like care for common orthopedic problems.

The following proposals can have a significantly improve the availability of relevant, meaningful information necessary to help consumers and employers to make better care decisions.

- ***Provide better, more consistent information on the quality of care***
 - *Chamber members will work to develop and then promote the use of consistent measures as part of payment contracts.* By using consistent measures developed from their own members' experience, businesses can help provide a "critical mass" of statistically meaningful measures of quality. These measures should be standardized so that plan's summary data from different employers can be combined without having to share any patient-level data as protected by the Health Insurance Portability and Accountability Act ("HIPAA"). To help assure that the measures can become widely available and are as constructive as possible, they should be well-validated and broadly supported, such as measures endorsed or intended for endorsement by the NQF. Clinician specialists can also help identify and promote the consistent use of quality measures based on best practices in their clinical areas. Chamber members will work with their health plans and providers to make the production of increasingly rich, consistent quality measures a routine part of their health insurance contracts.
 - *Medicare should contribute summary data to facilitate the development of comprehensive, accurate quality measures on providers and treatments.* NQF and the Centers for Medicare and Medicaid Services ("CMS") should

build on employer initiatives to advance consistent performance measurements across public and private programs. In areas where crucial gaps exist, if a critical mass of employers produce standard measures, Medicare should have a mechanism for contributing summary data to these quality measures as well.

- Because the resulting quality information will be valuable to everyone, including beneficiaries in federal health care programs, *the federal government should provide financial support for initiatives that offer consistent quality information on health care providers*. This could include supporting initiatives led by employer coalitions, or other public-private initiatives to make consistent and reliable measures widely available.
 - *Measures of the quality of care should be outcome-oriented and reflect patient experience. These measures should be able to account for important differences in patient characteristics and preferences that affect optimal treatment choices.* As medicine becomes more personalized, performance measures must be personally relevant as well. Measures should also incorporate efforts by physician organizations to document improvements in care through evidence-based best practices that lead to better outcomes.
 - *Gag clauses that affect the disclosure of standard quality measures or final cost information should be prohibited.* Provider-level summary data would not be personally identifiable, posing little privacy concerns for individuals.
- **Promote best practices for health plans to provide comparative information on the cost of care.**
 - Health plans and other companies are developing increasingly sophisticated tools to help people obtain and use meaningful information about the cost of services for individuals enrolled in health plans. Employers, the federal government, and others can do more to increase awareness and availability of these tools and encourage continued innovation. In particular, these personalized tools will become more effective when combined with the improved quality information that we intend to make available, as described above. The cost information most relevant to consumers is likely to be health plan- or employer-specific, and reflect the features of each consumer's coverage. Instead of prescribing how cost information is provided and used, the federal government should focus on supporting greater availability of personally relevant quality and cost information for consumers.
 - **Help consumers obtain consistent quality and cost information when assessing coverage options.**
 - The methods used by employers and private or public exchanges to help individuals compare plan choices are continuing to evolve; therefore, employers and others should focus on identifying and promoting best practices.
 - The information provided should include not just comparisons on premiums and quality of plan functions (e.g., customer service), but should

also include total out-of-pocket costs and expected quality for patients with common health problems by using the same kinds of measures developed for quality/cost comparisons across providers.

- Public and private initiatives should identify and promote broad-based, innovative approaches to provide consistent value information on health plans by building on the experiences of successful employer, regional, and state efforts to facilitate informed plan choices.
- It is important that government not mandate approaches that stifle innovation and exacerbate costs.

II. REALIZING GREATER VALUE IN HEALTH CARE: BUILDING ON SUCCESSES IN EMPLOYER-SPONSORED COVERAGE

a. Background

Countless studies by the Institute of Medicine (“IOM”) and others have repeatedly shown that health care costs are much higher and that outcomes are significantly worse than they could be. Unnecessarily high costs and poor outcomes are driven by:

- The earlier onset of preventable chronic conditions (e.g., asthma), generally caused by poor lifestyle choices (e.g., obesity, smoking, etc.) , are leading in turn to a growing prevalence of more severe diseases (e.g., heart disease, diabetes, and strokes);
- Poor care coordination, due to inadequate information sharing and lack of collaboration, are resulting in duplicative services and inefficient medical decisions;
- The underuse of high-value, low-cost services and providers, not merely due to lack of reliable evidence and personalized information, but also because patients and providers are not engaged and do not share adequately in the savings when they make informed decisions; and
- The underutilization of high-value treatments, such as some prescription drug regimens that have proven to be effective in preventing serious complications of many chronic diseases, again because patients and providers do not receive appropriate support for using high-value care.

Addressing these problems is fundamental to achieving higher value within the health care system and should be the main focus of health reform. Employers are leading many initiatives around the country to overcome these problems and help their employees improve their health at a lower cost while promoting the innovations needed to realize even greater value in the future. In many cases, they are doing this by moving away from traditional payment models that compensate providers for services rendered to more innovative payment methods that tie reimbursements to patient outcomes. Similarly by emphasizing personal engagement and responsibility with employees and beneficiaries, many employers and plans are making great strides in wellness, care coordination, and value-based insurance incentives which improve health and strengthen the value of the care individuals receive.

Unfortunately, many regulatory barriers stand in the way of this innovation. Beyond the impediments in the private sector, Medicare, Medicaid, and other public health care financing programs could also do much more to reinforce innovations, for example, by providing greater support for initiatives that help patients stay healthier and prevent complications, and by supporting more efficient, better coordinated care. Some important reforms now being piloted in Medicare and Medicaid hold some promise. However, the magnitude and urgency of the problem – and the availability of solutions – necessitates that we do much more to involve and support consumers in their care.

The Solutions Council has identified a set of policy reforms to support and advance health care delivery reforms that achieve greater health and wellness while reducing health care costs. Many of these proposals are *outcomes-oriented*. Health care financing, both provider payments and benefit design, should transition away from discrete services performed or provided to the patient and onto overall health by rewarding and encouraging better health and lower costs. These payment reforms and benefit design changes should also reflect the value of new technologies and treatments that provide longer term and systemic benefits in both cost and quality. These recommendations build directly on the Solutions Council's proposals to provide greater transparency on the quality and costs of care. Without these reforms, affordable, innovative coverage and care will be impossible to sustain.

Below are some examples of employer-led reforms that emphasize wellness, prevention, modern information technology and tools, innovative ways of providing care for chronic and advanced illnesses, and new technologies for achieving better outcomes.

b. Private Sector Leadership

i. Wellness Programs

Many employers promote wellness through a wide and increasingly sophisticated offering of resources to help employees and their families make healthier choices. Rewarding employees with financial support and enabling them to share in the health care savings and productivity improvements of better health encourages even greater employee participation.

Boeing has a Wellbeing Initiative that involves a strong internal communications, education, and preventative care initiative to motivate and assist their employees. One important component of this program is free annual physical exams for employees. The annual risk assessment survey has also helped engage employees in wellness activities. This survey has found that more than 60% of those with nutrition and weight problems reported that they were prepared to take steps to mitigate those risks through Boeing's Wellbeing Initiative, or other health improvement programs.

Dow runs a comprehensive health promotion effort for employees, their families, and retirees, including such benefits as seasonal flu shots at the worksite. Moreover, Dow offers a periodic preventive health exam for all employees on an age-based cycle that includes an assessment of lifestyle behaviors and biometrics. This exam is followed by a personal review and discussion with a health care professional. On-site fitness centers and fitness center membership reimbursement for worksites without on-site centers also promote wellness.

Eli Lilly and Company (“Lilly”) has a health services department in Indianapolis that offers services such as: emergency medical; allergy injections; preventive health care such as digital mammography, laboratory tests and immunizations;

Body Mass Index calculations; laboratory work; care for occupational injuries and illnesses. The department annually logs more than 31,000 clinical visits for employees' personal needs and has built a new Life Building at Headquarters Main Campus in Indianapolis that includes:

- Free individual fitness assessments and plans;
- Free wellness coaching for Fit for Life members;
- Group fitness classes;
- A bike hub for commuters with showers and indoor storage – and even 25 bikes to borrow if you want to ride for exercise;
- A snack bar where even the snacks are healthy; and
- A one-fifth-mile outdoor track and multi-purpose athletic field.

Johnson & Johnson ("J&J") operates a comprehensive, holistic onsite employee health program that combines health promotion, occupational health, and mental health services. Intended to be integrated fully with the organization's culture and supported by its own department at J&J, the program includes a core set of services offered at each of the 200+ operating companies, with additional services tailored to the specific site and employees' needs. Under the program, participants receive a financial incentive to complete a health risk assessment. Employees with specific health risks have the opportunity to speak with a health adviser to develop a specific, customized plan for reducing identified risks. The program has achieved very high participation rates, and has significantly reduced risk factors (such as physical inactivity, smoking, high blood pressure and cholesterol). It has also helped reduce overall corporate health care spending and increased productivity. In a recent outcomes' evaluation analyzing data collected from 2002 to 2008, J&J's U.S. health and wellness programs were found to achieve an estimated return on investment averaging \$1.88 to \$3.92 for every \$1.00 invested. The annual savings per employee per year was estimated at \$565.00. Additionally, the outcomes study showed significantly lower average growth in medical and pharmaceutical costs (3.7%) each year between 2002 and 2008.

Two years ago, **Marriott** launched their TakeCare Wellness program to support employee health. Employees at about 98% of Marriott hotels received a 90-minute presentation on the importance of wellness and the tools available to help them take greater accountability for their health. Since this launch, Marriott has had six national challenges that range from "Maintain, Don't Gain" campaigns right after the holidays to "Shape Up with Marriott"—a social media challenge with different competitions for employees including walking and weight loss challenges. So far, Marriott has received an overwhelmingly positive response and is currently assessing the impact on medical costs. Other wellness efforts include a smoking cessation program. Medical plan participants also have access to free health coaches, and Marriott recently placed on-site health coaches at select properties to further engage employees and help them get the most out of their medical plans. In addition to providing chronic conditions management assistance, these health coaches help employees to take advantage of free preventive services, understand

their medical benefits, and choose the highest quality and most cost-efficient doctors and hospitals in their areas.

Vanderbilt Health and Wellness has established a health education and incentive program for employees to help identify their risk factors for health problems and work on risk mitigation. There has been a 90% participation rate over a three-year period.

UHG has developed UnitedHealth Personal Rewards, a program that provides support and rewards for members to make healthy choices in their daily routines. Created in 2010 and adopted by over 40 large employers, this program serves more than 2 million people and helps individuals: better understand their health; pursue healthy behaviors in wellness programs; and receive support in their efforts to lose weight. Employers that have adopted this program have seen positive provider utilization changes also, such as increases in wellness exams and fewer emergency room visits. As a result, the program has demonstrated a 19.6% reduction in diabetes-related complications, a 12.3% decrease in coronary artery disease costs, a 3.3% reduction in hospital admissions, and a 5% reduction in emergency room use. UHG also uses OptumizeMe, a program designed to raise personal awareness of important wellness issues and encourage people to not only take a more proactive role in their own health but also motivate their social networks. The mobile application enables users to create and challenge each other to fitness competitions and trade both encouragement and “digs” along the way. The application tracks their progress on challenges, and rewards them with virtual badges as they achieve their goals.

To prevent diabetes among individuals at risk, UHG has partnered with the Centers for Disease Control and with non-traditional providers such as the Y-USA to deliver the Diabetes Prevention Program (“DPP”). DPP helps people with pre-diabetes prevent or delay the onset of the disease through healthy eating, increased physical activity, and other lifestyle changes. DPP won the U.S. Department of Health & Human Services’ 2011 Healthy Living Innovation Award. Moreover, DPP participants have high completion rates (with participants attending an average of 13 sessions out of the 16 offered, and 75% of those that attend at least one session going on to complete the program) and a 5% mean weight loss for participants.

ii. Care Coordination

In conjunction with wellness programs that prevent illnesses, many employers have efforts underway to support the delivery of higher-value care to people with complications and chronic health problems. These programs include initiatives to help employees avoid complications from their health conditions. Because these programs use health care financing reforms to reward better care, they generally involve collaborations between employers and their medical plan administrator or health insurers. Medicare Advantage

(“MA”) plans are also bringing these services to Medicare beneficiaries with chronic illnesses to help individuals and their providers achieve better health at a lower cost.

CVS Caremark has initiatives to enhance medication adherence to improve health outcomes and avoid disease complications. Analyses of their data show that improved medication adherence can significantly lower overall health care costs, in particular addressing the estimated \$300 billion in additional health care costs each year resulting from missed opportunities to use medications effectively. To address this problem, the CVS Caremark Pharmacy Advisor initiative began with diabetes case management and has expanded to include 13 different conditions where medications can have significant effects on reducing health complications. This program follows members’ pharmacy behavior regardless of where they fill their prescriptions and offers help in using the prescriptions effectively. Pharmacy Advisor has demonstrated a 70% uptake in people getting back on their prescriptions and shows the effectiveness of this face-to-face model.

Dow, in collaboration with their plan administrator, actively promotes the Patient Centered Medical Home model in Michigan and in other locations around the country. This collaboration includes a per-member-per-month (“PMPM”) payment against future savings to support the physician transition to this model. In addition, Dow has established an electronic Personal Health Record (“PHR”) that is now available to all Dow employees and their families.

UHG has a program called HouseCalls that provides an in-home assessment and support for Medicare beneficiaries at risk of hospital readmissions. The assessment is performed on a tablet and is used as a basis for implementing care management services to improve the quality of care. The program provides members with free in-home doctor or nurse practitioner visits following their discharge from the hospital, during which the doctor or the nurse practitioner completes a thorough assessment pertaining to common post-hospitalization issues and preventive care. This information is fed back to the clinical team responsible for ongoing member support and communication with primary care and specialist providers. The HouseCalls visit can also: trigger alerts for potentially urgent health issues; identify issues for patients to discuss with their primary care doctor; and recommend follow-ups to the primary care physician. UHG also uses Optum’s eSync platform, which combines data from different sources for each patient and then delivers customized health care management tools to individuals directly and via their care providers. By combining a wide range of health data such as medical claims, health and lifestyle choices, and demographic factors, UHG can turn this information into a practical blueprint for effective, personalized plans based on a member’s actual health care needs. Optum’s eSync also powers the ability to proactively reach out to high-risk customers and offer them the opportunity to participate in programs specifically designed to help them reduce their health risks. For nurses, clinicians, health coaches, physicians, and others, the eSync platform also provides enhanced visibility into a patient’s medical history and real-time medical profile which can result in better health management

and potentially significant savings for individuals, their employers, and the health care system as a whole.

WellPoint owns an MA plan called CareMore, which employs specially trained physicians called “extensivists” to carefully monitor every aspect of their frailest members’ care. The extensivist is responsible for: conducting pre-operative exams and managing the patient hospitalization decision; taking control of the entire inpatient stay including specialist consultation, diagnostics, primary care provider communication and family communication; creating and managing the discharge plan; and following the patient through any skilled nursing stay and on an out-patient basis until the acute episode or frailty is resolved. The extensivist also manages high-risk patient events such as fall-prevention programs and dementia evaluations. Finally, the extensivist assists with the transition to palliative care and end-of-life teams as appropriate. The CareMore model has resulted in a readmission rate reductions of 6% compared to the average Medicare rate.

iii. Value-Based Insurance Incentives

While the use of financial incentives and support systems for providers is vital to achieving greater value in health care, reinforcing these steps by supporting and involving consumers – including those with chronic illnesses – can have an even greater impact on health care value. Some of these consumer focused initiatives include financial incentives and other value-based insurance designs, while other employer-sponsored programs reward employees for using health care services more effectively. Partnerships between employers and their health plans or plan administrators have been effective in supporting employees, as have regional collaboration across multiple employers.

Aetna offers A Performance Network (“APN”) in which employer sponsors have the option of creating benefit design incentives using the network’s offerings. APN is designed to encourage members to access high-value care by tiering the plan design to promote a specific network of select providers and hospitals. Aetna’s value-based design includes reductions in out-of-pocket costs for members when they select specialists and hospitals that Aetna has identified as demonstrating high clinical quality and cost effectiveness. APN promotes alignment between designated specialists and hospitals, making it easier for employees to seek care within the network. Based on its 2012 network performance, Aetna expects up to 5% average savings on total medical costs. APN has the potential to influence approximately 70-75% of total medical costs, and it is expanding to have a greater impact on clinical quality and medical cost savings.

Health Care Service Corporation’s (“HCSC’s”) Value-Based Insurance Design product was offered to approximately 25 employer groups in 2012. The goal of the product is to align a patient’s out-of-pocket costs with the overall evidence-based value of services. Although in the short term the program is expected to drive up utilization and the costs of important maintenance medications and other “secondary prevention” services, it is also expected to reduce the much larger

health claims for significant disease complications in future years. This product is currently aligned with the Blue Care Connection suite of Condition and Lifestyle Management programs. Pharmacy, medical, and supplies/equipment are currently offered for two conditions —Coronary Artery Disease (“CAD”) and diabetes. Other conditions where effective use of medications has been shown to lower future complications and cost, such as asthma, Chronic Obstructive Pulmonary Disease (“COPD”), Congestive Heart Failure (“CHF”), hyperlipidemia, hypertension, Metabolic Syndrome (“MetS”), and tobacco cessation, qualify for the lower co-pays for pharmacy benefits.

At **J&J**, U.S. employees who complete a voluntary health assessment qualify for a \$500 medical benefit plan discount. The online assessment tool covers the major health risk areas: obesity, cholesterol, glucose, hypertension, tobacco use, physical inactivity, stress, alcohol use, unhealthy eating, safety belt usage, and depression. Those at risk for identified complex conditions receive a referral to the company’s CareConnect care management program and receive an additional financial reward which is deposited into their health reimbursement arrangement if they actively participate in the case management process. Other benefit incentive programs offered include a maternity management incentive for pregnant employees or their enrolled spouse/partner. Employees can also receive incentive payments for receiving a screening colonoscopy.

An example of a multi-employer, regional collaboration to provide better support and incentives for employees to prevent health problems is the **Kansas City Collaborative** (“KC2”). This was a three-year value-based benefit project involving 15 innovative Kansas City area employers and led by the nonprofit Mid-America Coalition on Health Care. The goal of KC2 was to help employers develop, implement, and maintain a workforce health strategy to improve employee health and stabilize health care cost trends. Employers participating in KC2 focused on specific measurable health improvement objectives, including: establishing or enhancing their health management team, improving access to actionable data, and aligning benefits with desired health outcomes. The employers analyzed their specific workforce data and evidence on best practices, and then implemented a set of benefit, environmental, and policy changes. Preliminary benefit changes that have been reported to date by approximately half of the participating employers include: chronic condition management with reduced or waived co-pays (92% of employers), reduced or waived co-pays for preventive care services (92% of employers), and annual premium discounts or rebates for out-of-pocket enrollment costs for wellness initiatives based on employee participation or behavior change achieved in weight management or smoking cessation interventions (85% of employers).

Marriott offers a value-based incentive design for prescriptions drugs used for chronic conditions such as heart disease, diabetes, and asthma. If employees participate in the program, generic drugs are available with no copayment and payments for brand name co-pays are cut in half. For organ transplant and

bariatric surgeries, Marriott requires employees to use specific, approved providers with a strong track record for higher quality and lower cost (i.e., experienced providers with low complication rates who have lower overall costs as a result). If an employee chooses not to use the approved provider, referred to as “Centers of Excellence,” the procedure is not covered by the plan.

UHG has designed its Diabetes Health Plan to help enrollees manage their diabetes while reducing their out-of-pocket expenses by as much as \$500 annually through enhanced benefits in exchange for compliance with preventive care guidelines. The Diabetes Health Plan is an example of a value-based benefit that provides financial benefits for consumers to practice healthier behavior. Consumers receive richer benefits, or lower out-of-pocket costs, if they commit to fulfilling the American Diabetes Guidelines such as receiving blood sugar tests at least twice annually or diabetic retinal exams once annually. In exchange, they receive lower out-of-pocket costs, such as no co-pays for their diabetes, hypertension or cholesterol-lowering drugs.

All of these examples illustrate a strong and growing commitment by employers and the plans they work with to reform health care by using various value-based insurance designs as well as other supports and incentives for employees to obtain higher-value care. These innovative products and programs have been adopted more extensively by employers and private sector coverage than by traditional Medicare, Medicaid, and other public programs. Both the limited use of, and tight restrictions on, value-based consumer reforms in public programs, coupled with a regulatory barriers such as new limits on value-based and consumer-directed benefit designs in employer plans, limit opportunities for lowering health care costs through prevention, better care, and better health. Overcoming these obstacles is essential to achieve affordable, sustainable, high-value health care.

iv. Health Information Technology

Health Information Technology (“health IT”) has tremendous potential for improving patient care and lowering health care costs, by providing essential support for value-based insurance design, wellness and prevention, and care coordination initiatives. The convergence of medical advances, mobile medical applications and cloud-based electronic health records (“EHRs”) can transform the delivery of care by bringing the provider and patient together virtually, especially in disadvantaged areas. With an electronically mobile-dependent population, more personalized support, and the emphasis on convenience in other industries, people are demanding and expecting access to care from anywhere and at any time – whether it is from a home in a rural area or an apartment in the city. But health IT has not yet come close to fulfilling its potential.

For example, a study conducted by the **IBM Institute for Business Value** showed that consumer demand for information-driven health and wellness is growing exponentially as more devices and applications are introduced to the market. This study indicated that a majority (over 60%) of consumers have or are caring for others with chronic illnesses.

Consumer demand will only continue to accelerate as more consumers want: to use their devices to connect to their doctor; to reduce the need to travel to the doctor or clinic for care; and the ability to engage in their own care through social media and emerging self-diagnostic devices. In turn, doctors and caregivers are also eager to leverage technology to obtain the appropriate information in a timely manner to efficiently and effectively treat patients. The study also showed people are willing to pay for this convenience; one-third of current smart device users are willing to pay for the devices and recurring fees to access care from anywhere and at any time.

The coupling of health care delivery reforms and payment reforms in entities such as Medical Homes and Accountable Care Organizations (“ACOs”) would permit individual to access care easily while facilitating: cost-effective care delivery; licensure portability in a mobile society; and the rapid adoption of health IT and telehealth. In these systems, the fee-for-service model is being replaced with a coordinated care payment model. For the coordinated care model to work, providers must be able to treat their patients anywhere, without artificial borders and by leveraging technology. Similarly, regional information and insurance exchanges require effective and secure linkage to plan, provider, and patient data in order to work effectively.

Disadvantaged and underserved communities stand to benefit most by the facilitation of health care delivered anywhere, anytime. Many individuals in these communities suffer from chronic health conditions like heart disease and diabetes. They receive less preventive care, such as mammography and pap smears for women, or routine foot, eye, and blood testing for diabetes and other manageable conditions. Over 50 million Americans lack access to primary care services due to doctor and provider shortages at local practices, community health centers, and hospitals. In many rural communities, patients must travel long distances to health care providers to receive treatment. In urban areas, others must travel across town taking multiple buses, trains, or taxis. Recent innovations in consumer smart devices and applications enable the patient and provider to connect virtually at the point and time of care.

As our country faces an increasing demand to access care from anywhere at any time and the growth of chronic diseases, and provider shortages, harmonizing the various state-based scope-of-practice and licensure rules is critical. Synchronizing these rules would: maximize limited resources; leverage the opportunities of telemedicine/telehealth; and expand the capacity of health care delivery systems.

Key changes to leverage health IT and facilitate the delivery of health care anywhere at any time include:

- Implementing interoperable technologies that can openly exchange patient information;
- Allowing health care providers to use technology to care for their patients and provide expertise anywhere and anytime; and
- Stimulating advances in health technology instead of stifling innovation.

The transformation of the health care system is hindered by IT systems that cannot interface with other systems and the current state-based system of medical licensure. Innovation in the development of devices and mobile applications that can drive better outcomes for patients through health IT is also hindered by uncertainty about the regulation of these new technologies.

c. Principles and Proposals

These proposals describe ways to build on steps that employers and plans have taken to advance: wellness; better quality care; and better health care choices through *outcomes-based* reforms. They include payment and benefit reforms that reward providers and patients for better results.

Additionally, better information on the quality and cost of services will facilitate the ability to adopt and advance these new payment models which will redirect payments to support innovative approaches that deliver better results. Similarly, structuring benefits around better providers and better services and basing incentives on better health will enable and encourage patients to save when they take steps to improve their health.

These proposals also focus on adopting more outcomes-based regulatory approaches. Regulations must facilitate, and not impede, progress toward innovative care that achieves better results.

- **Promote Outcomes-Based Health Care Payment and Benefit Reforms**
 - *As a significant number of employers work with health care providers to adopt value-based payment reforms, providers should be similarly financially rewarded by Medicare.* Today, many physicians, hospitals, and health care organizations are shifting to payments based in part on results, but these same measures and payment methods cannot be adopted easily in Medicare. Multi-payer reforms, especially those developed by employers working collaboratively with health care providers, would help ensure that progress in delivery reform is not impeded by initiatives that pull providers in different directions.
 - *Employers offering coverage should have more flexibility to establish consumer-driven health plans and value-based insurance designs.* Consumer-directed plans, including Health Savings Accounts (HSAs) and Flexible Spending Accounts (FSAs), have provided a low cost and increasingly popular way to enable employees to save money when they choose lower cost health care services and products. But recent regulatory guidelines regarding premium incentives allowed in employer-provided coverage limit how employers can implement these incentives. Recent restrictions on HSAs and FSAs should be eliminated.³ Regulations that limit employers' ability to provide financial incentives for employees to

³ However, it is possible that reducing restrictions on HSAs and FSAs could lead to an increase in bad debt for providers.

take steps to improve their health and wellness and to use high-value providers should also be relaxed. Employers have been able to implement plans that provide financial incentives and support for better health in ways that facilitate broad employee participation regardless of health status, while providing many tools and other supports to enable employees to take advantage of these opportunities. Employers have also implemented value-based designs in ways that provide effective access to care for patients with serious and complex illnesses, and that reflect the value of innovative technologies in particular cases. These approaches should be encouraged, by removing recent regulatory restrictions such as the financial limits on employers' abilities to offer non-discriminatory wellness incentives

- *Insurance exchanges should support plans that enable consumers to reduce premiums and allow flexibility for innovative plan and network design. Plans should be allowed to enable consumers to reduce premiums and copayments when they take steps to better health and to use health care services more efficiently. Insurance exchanges should facilitate the ability of consumers to choose these types of plans through easily accessible resources.* The same kinds of non-discriminatory wellness and care improvement programs that are increasingly part of employer-sponsored coverage should be available for individuals participating in the exchanges. We describe these regulatory issues in more detail during the discussion of needed reforms in insurance exchange regulation in Section III. *Similarly, MA plans should have greater opportunities to use value-based plans to provide greater support for beneficiaries to improve their health and use higher-value providers.* Regulations that restrict the ability of MA plans to provide incentives and share savings with beneficiaries who participate in wellness programs or choose high-value care should also be reformed. Employer health plans have shown that such incentives can be designed and implemented in a way that encourages a broad range of enrollees to make decisions that lead to higher-value care and lower costs, particularly those with chronic illnesses.

- ***Move Toward Outcomes-Based Regulatory Reform***

- *Insurance regulation should promote higher quality and lower-cost outcomes.* Many current insurance regulations at both the state and federal level, including in the MA program, are intended to improve access to quality care for consumers. Yet many regulations focus on structural criteria for health plans (i.e., structural measures of “network adequacy”) without verifying the connection between the structural requirement and the goal of access to care. As a result, innovative approaches to delivering care (e.g., through alternative sites of care, innovative treatments, telemedicine and Internet-based services, and high-value providers) may be prohibited. With better measures of patient outcomes (e.g., patient experience with wait times, improved outcomes for the conditions involved, patient and caregiver experience with post-acute and long-term care, etc.), such regulations could be modified to focus less on the

structural criteria and more on whether desirable results for patients are being achieved. This would promote innovative plan designs and health care delivery reforms that improve access to high-value care.

- *Provider regulations should focus on quality and cost outcomes.* The use of outcomes-based measures and cost-containment efforts should take into account the benefits of personalized medicine and variation in individual outcomes.
 - For access concerns explained above, “scope of practice” restrictions and state licensure requirements should be harmonized so that all providers can practice to the top of their licensure and so that medical expertise can be shared across state borders. For example, instead of significantly different requirements or limitations on providers of telemedicine services from state to state, a reciprocity program or a national licensing option could be established for telemedicine programs that rely on out-of-state providers, when these programs demonstrate high value or the ability to improve access to care in underserved areas.
 - Stark, Anti-Kickback, and other regulations prohibiting financial interactions among providers should focus more on health outcomes for providers who are at financial risk for improving outcomes while lowering costs and who must work in new ways to do so. But providers who have shifted to such outcomes-based payments are often better able to coordinate care, reduce duplication, and achieve higher-value results when they have financial interactions. For example, hospitals providing financial support for physicians are able to track patients electronically and coordinate care. To assure that these regulatory reforms do not lead to higher costs, providers should demonstrate that their new integration is improving quality and cost outcomes.
 - The medical liability system must be reformed to give health care providers more support in delivering high-value care. Current liability laws often encourage overtreatment and can reduce access to needed specialty services instead of supporting high-value care. Medical liability reform is critical to lowering health care costs without compromising quality. Important reforms include placing caps on damage awards and other previously proposed reforms, as well as “health courts” and presumptions or safe harbors based on evidence-based medical practice guidelines, demonstrated patterns of safe and high-quality care.
- *Regulation of employer plans should focus on quality and cost outcomes.*
 - Anti-trust laws should provide more flexibility to allow employers to contract with providers in ways that place providers at greater financial risk for achieving high-quality and efficient care. While the movement away from paying for volume means new kinds of financial risks for providers, it also means more support for delivery reforms that increase value. Anti-trust protections should be

- modernized as necessary to encourage such value-focused payment reforms.
 - Employers should have more flexibility in their Medigap designs to provide value-based incentives, so that retirees can save when they take steps to stay healthier and use care more efficiently. In the meantime, before legislation is enacted to permit this flexibility in Medigap, Medicare should consider working with employers to pilot such reforms, and enable employers to share in any overall Medicare savings.
- ***Advance the Adoption of Interoperable Health IT Systems Nationwide***
To reduce unnecessary duplication, improve access and achieve more high-value outcomes, we should:
 - Encourage the development of a *health information exchange through interoperable health IT network* to connect and expand access to health care anywhere and at any time;
 - Promote and implement *open, real-time exchange* of health information and integrate coordination of technologies;
 - Support technologies that enable continued development and expansion of ACOs; and
 - Permit physicians to *practice telemedicine across state lines* without requiring licenses in each state and integrate coordinated care payment models.

III. ADDRESSING THE CHALLENGES OF HEALTH INSURANCE REFORM: SUPPORTING EFFECTIVE EMPLOYER-SPONSORED COVERAGE AND PRIVATE INSURANCE OFFERINGS

a. Background

Employer-sponsored health coverage has always been an important component of employee compensation and is critical for businesses to attract and retain employees. However, providing affordable health insurance coverage is becoming progressively more challenging with new restrictions on plan design and new requirements governing employer-sponsored coverage. Despite the obstacles to promoting wellness and efficient care, employers of all sizes have developed programs and products that their employees value and remain committed to ensuring that their employees receive high-value health care.

Ideally, the PPACA would reinforce employers' innovations and commitments in providing high-value coverage. Theoretically, the exchanges and the new requirements and regulations affecting employer-sponsored coverage were meant to facilitate access to high-quality, affordable coverage options and reduce unnecessary costs and expenses by rewarding healthy behavior and the effective use of high-value care. However, the PPACA reforms will obstruct access to affordable coverage for employees if not carefully and gradually implemented. For example, overly broad specifications of Essential Health Benefits ("EHBs") and overly expansive interpretations of statutory limits on out-of-pocket maximums may not only deter employer innovations in coverage designs and employee efforts to use care more efficiently, but may also price plans out of reach for most consumers. Regulations issued to date requiring plans to provide more "comprehensive" coverage on paper may not achieve the practical reality of enabling employees and employers to actually purchase that coverage and access care at an affordable price. Instead, individuals and businesses will not be able to purchase any coverage at all. Left unchanged, the bulk of the PPACA insurance reforms will make it much more difficult for employers to help their employees obtain coverage and access the care they need, leading to less productivity, more costly products and services, reduced competition, and slower economic growth. These harmful effects are likely to be particularly significant for the 30 million employees of businesses with fewer than 50 employees and their dependents.

To mitigate the harmful and lessen these unintended and damaging outcomes, the Solutions Council's employers have identified specific solutions, as well as additional opportunities to improve care and affordability. Some solutions could be achieved through the regulatory changes and should be advanced as soon as possible; others would require legislative modifications and warrant Congressional attention now. All are geared to achieving the goals of greater access to affordable coverage, innovative care, and better health, building on the private sector innovations in benefits, payments, and health and wellness programs that have been an integral part of employer-led health care reforms.

As implementation proceeds, the Solutions Council members and the Chamber expect to continue to assess and evaluate the impact of these reforms. Timely and constructive feedback, building on the comments provided here, should be used to help smooth the PPACA implementation process. To support this effort, accurate and clear information about the availability and take-up of affordable, quality coverage will be critical. As these factors are monitored, further changes to mitigate unintended harmful outcomes may be necessary.

To better advance the goals of better health and access to affordable coverage, the Solutions Council proposes several recommendations to permit greater flexibility and facilitate greater innovation in plan design, benefit variation, and health and wellness programs. Additionally, to ensure more efficient implementation, the Solutions Council strongly recommends that some of the major elements of the PPACA be rolled out in a more incremental way. Without a more modest transition, the goals of the law will be undercut. By phasing in certain insurance reform requirements, the impending significant rate increases that will otherwise begin in 2014 can be mitigated. However, without such a phase-in, new insurance rating requirements will substantially increase health insurance premiums in 2014 and significantly disrupt access to coverage and care for millions of employees and individuals.

Finally, several specific components of the law must be modified to ensure that employers can continue to grow their business and that both employers and plans can encourage individuals to make appropriate choices and reduce unnecessary health care costs while providing affordable coverage, and to support growth in employment and wages.

b. Private Sector Leadership

i. Employer Concerns About the Impact of the PPACA

The most important concerns expressed consistently by employers are that the PPACA will interfere with their ability to sustain and increase jobs and wages, and to offer affordable coverage that promotes greater health care value and keeps overall health care costs down. As noted in Section II, many employers, small and large, have taken steps in recent years to address rising health care costs by putting a greater emphasis on effective, high-value care with the hope of avoiding costly medical complications.

For example, a steadily increasing number of small businesses are relying on HSAs and High Deductible Health Plans (“HDHPs”) to help slow cost growth, with encouraging results. Although the plans coupled with these accounts typically have a lower actuarial value (“AV”), the accompanying tax-preferred accounts provide additional financial support to pay for certain medical expenses while also giving individuals more financial interest in controlling their health care spending. Much of the savings comes not from shifting greater cost onto the individual but from behavioral changes in spending that these accounts encourage. Moreover, innovations in HDHP design are also addressing concerns such as the reduced use of effective care (i.e., through low or no co-pays for preventive

services and needed drugs for chronic diseases) and cost-shifting to providers through increased bad debt.

These plans are growing in popularity because they not only provide effective and less expensive coverage but also because they have reduced cost trends for employer coverage. Unfortunately, the new restrictions being implemented in the PPACA regulations may disrupt these plans, much to the concern of many employers. One small employer on the Solutions Council noted that by offering a HDHP while also providing employees with a significant employer contribution to the HSA, the business's health care costs have been reduced by 15%. However, the employer fears that this strategy will no longer be allowed even though the employer's significant HSA contribution protected employees from very high out-of-pocket costs by effectively paying the deductible. This company expects to have to shift some of the higher costs of coverage under the PPACA to employees in order to continue offering health insurance. Other small employers, especially those providing jobs to less-skilled workers, believe they will not be able to hire full-time workers and continue offering insurance coverage because their plans cannot meet the regulatory requirements at a cost that they and their employees can afford. As one employer put it, his employees will not be willing to pay the cost of a change in health coverage to meet the new requirements. Large employers also have concerns about cost increases resulting from new fees and administrative expenses (i.e., the reinsurance fee and the summary of benefits and coverage).

Many employers have implemented other types of "value-based" benefit designs which include initiatives that support healthy behavior and the use of preventive services and high-value providers by providing opportunities for individuals to share in the health care savings. For large employers, such benefit designs, along with extensive wellness and prevention programs, are a cornerstone of their strategies to improve employee health and reduce costs. Many large employers are concerned that the new PPACA regulations will restrict their ability to offer such plans. Instead of expanding the availability of plans that reward employees for seeing high-value providers, these regulations may shift more employees into exchange-based plans that may be prohibited from offering such incentives. This would undermine employer efforts to work with employees to improve health and avoid unnecessary health care costs. For example, some large employers have noted that they have had to slow their efforts to implement value-based reforms, due to the uncertainty about regulatory requirements and the future viability of the coverage that they are offering their employees.

With only a finite amount of money available for a business to spend on compensation, whether in the form of wages or benefits, as the cost of coverage increases, employers fear that they will be forced to further increase the portion that employees pay in premiums and co-payments.

The employer concerns identified by the Solutions Council are widespread. For example, a recent Gallup survey of small employers found that four times as many small business owners believe that the PPACA will reduce the quality of care for their employees as opposed to those who believe that it will improve quality (52% versus 13%). Eleven

times as many expect that the PPACA will increase their health care costs as opposed to those who believe that it will reduce costs (55% versus 5%). Overall, 48% of small business owners believe that the PPACA will be bad for business, compared to only 9% who expect it to have a beneficial impact. These expectations are forcing action: employers are holding back on hiring new employees (41%), or have slowed plans to grow their business (38%).⁴ In the same vein, the Chamber's Small Business Outlook Survey⁵ released in April 2013 found that:

- The requirements of the health care law are now the biggest concern for small businesses, having bumped economic uncertainty from the top spot which it has held for the last two years.
- Of small business respondents, 77% say the health care law will make coverage for their employees more expensive, and 71% say the law makes it harder for them to hire more employees.
- As a result of the employer mandate, 32% of small businesses plan to reduce hiring, and 31% will cut back hours to reduce the number of full-time employees.

ii. Particular PPACA Provisions Responsible for Employer Concerns

Unfortunately, these employer concerns are well-founded. Despite years of success in encouraging consumers to maintain and improve health while using medical services more effectively, health plans that encourage both more active consumer and provider engagement face considerable risks under the PPACA. Employers have extensive experience with the tradeoffs between coverage affordability and access to care in many current benefit designs highlight the need to closely monitor these issues during implementation. Indeed, the innovations in employer coverage that we have described represent promising approaches to promote both affordability and needed access. Substantial new requirements on coverage may interfere with these innovations and thus warrant considerable caution and close monitoring in their implementation, to ensure that their intended effects on promoting access are not offset by higher costs and less take-up of coverage.

In particular, there are five general areas where implementation may jeopardize valued employer strategies to improve health and drive value. However, there are ways to mitigate the harm that could be caused by: expansive interpretations of the out-of-pocket maximum limitations and the deductible limits; detrimental calculation methods for the actuarial value of a plan; broad definitions of preventive services; inadvertent policies that fail to encourage continuous enrollment and encourage healthy behavior.

First, many of these plans have deductibles and co-payments that vary depending on the treating provider to encourage employees to obtain care from higher-value providers. For

⁴ Gallup, May 10, 2013, available at <http://www.gallup.com/poll/162386/half-small-businesses-think-health-law-bad.aspx>.

⁵ U.S. Chamber of Commerce, "Q1 U.S. Chamber of Commerce Small Business Outlook Survey," April 2013, available at <http://www.uschambersmallbusinessnation.com/community/q1-2013-small-business-survey>.

example, these tiered networks provide employees an opportunity to save when they elect to see preferred providers that have been identified as having better outcomes. These plans also typically give employees more opportunities to save when electing lower-cost, but more effective, care options and use “in-network” providers that meet quality standards. Such plans are often paired with FSAs and HSAs that allow individuals to save and then use tax-free dollars to pay for certain health services and items, which also helps to keep medical expenses manageable. A uniform *cap on out-of-pocket maximums* that potentially applies to all plans and the *limits on deductibles* (\$2000 per individual and \$4000 per family) imposed on small group plans by the PPACA could severely hamper or eliminate these strategies.

For example, if the out-of-pocket (“OOP”) maximum applies to care from lower tiered network providers, beneficiaries will easily exceed the OOP limit anytime they have a major procedure done by a less favored provider. This would eliminate the ability of plans to reward consumers when they use providers that deliver care more efficiently. Similarly, if the deductible cap is imposed broadly on these plans, the deductible limitations could eliminate HDHPs and the HSAs that accompany them.⁶

Second, the *prohibition on plans with an AV less than 60%* could also inhibit these same types of high-value coverage. This is especially likely if this AV calculation of a HDHP fails to account for the full employer contribution to the plan’s HSA or if the AV calculation includes the lower compensation rates for the HDHP’s out-of-network providers.

Third, new requirements on health insurance plans could also increase costs without providing commensurate value to improve the health of employees and their dependents. Broad requirements for EHBs could inhibit the strategies that employers and plans are using to support high-value care. For example, if EHBs are interpreted to include generous coverage for costly services where less expensive but effective alternative treatments or providers exist, premiums will rise significantly. Further, since the federal government is responsible for the additional cost of existing state-mandated benefits in the exchanges, there is little incentive for states to reevaluate and update these older mandates to avoid unnecessary costs. Concerns about the definition of EHBs extend beyond simply those plans in the small group and individual markets which are required to cover all EHBs. There are ramifications for plans in the large group market as well, since no plan may place an annual or dollar limit on an EHB plan. For plans in the large group market that are not required to cover an EHB, but that may not impose an annual or lifetime dollar limit on that benefit if they do, employers may be left with no option but to stop covering

⁶ While the Chamber supports value-based insurance design and the ability to vary co-pays and deductibles for various reasons, there are other important access ramifications to weigh as well. While greater flexibility in the area of cost-sharing may facilitate the ability to offer more affordable plans with lower premiums, it may also impede patient access to services. This tension between ensuring individuals can access coverage (buy insurance) and access services (seek treatment given co-pays once insured) turns on the balance between affordable premiums and affordable treatment; this tension and balance must be closely monitored during implementation.

the benefit. One example is durable medical equipment (DME). Because the PPACA does not allow annual or lifetime dollar limits on EHBs, if DME is defined as an EHB by a particular state, a large employer would be forced to either exclude this benefit or cover it on an unlimited basis.

Fourth, a *broad prohibition on any cost-sharing for preventive services* could have similar undesirable effects. Prevention is an essential part of high-value health care, and the Solutions Council's proposals are intended to provide much stronger support for moving toward a prevention-oriented health care system. However, requiring that *all* "preventive" services for all people have zero dollar co-payments will drive up costs. Instead, an evidence-based approach that includes an analysis of costs as well as benefits should determine which services are appropriate to require plans to cover with zero dollar co-payments. Beyond the first-dollar coverage of an expansive array of these services, the broad categorization as to which providers must be covered for these services may also make prevention more costly than necessary.

Finally, *very broad underwriting restrictions and new community rating requirements*, coupled with other concerns about implementation like near-continuous open enrollment, will exacerbate the detrimental effects that each of these changes would have alone on the insurance markets and the cost of coverage. Higher costs will only force more employers to stop offering, and therefore more employees to stop enrolling in, high-value coverage. Broad prohibitions on underwriting may go well beyond their intended effect of ensuring that all Americans can continue to obtain coverage. Instead, individuals will have little reason to remain continuously enrolled in coverage, even when they are at risk of worse health or they change jobs, since they will be guaranteed an issuance of coverage which will be rated based on the community and not their individual health. Without good reasons to stay continuously enrolled in coverage, people with lower health risks may drop out.

Without the opportunities to save money in the form of lower premiums when they take steps to reduce their risk factors, employees won't be able to achieve the financial benefits of participating in the wellness and chronic disease support programs that have been expanding in employer coverage.

iii. Simulations of the Impact of PPACA Provisions

Beyond the effect these provisions will have on innovative plan design, these provisions will also impact premiums. There are four general types of PPACA provisions that will increase premiums and a growing number of independent studies are consistently analyzing the impact on employers and employees obtaining coverage in the large group market, as well as individuals purchasing coverage on their own. To be sure, many predict very large premium increases for many employees and are expecting that employers will drop coverage or change the nature of the coverage they provide. However, although analysis at the national and state level for premiums in these markets is telling, there is a dearth of information on the premium impact on the coverage small businesses purchase.

A. Provisions Increasing Premiums

The increases in the cost of insurance coverage will come from multiple sources that can be grouped into four general categories of PPACA provisions: new taxes and fees, additional benefit and coverage requirements, new premium rating restrictions, and potential adverse selection.

First, the PPACA imposes *a variety of new fees* on private insurance products. The 3.5% user fee on insurers offering exchange plans in states with a federally-facilitated exchange (“FFE”), the new tax on health insurers (health insurance providers fee), the “transitional” reinsurance fee to stabilize the health insurance exchanges’ individual markets, and other taxes and fees (such as the assessment for the Patient-Centered Outcomes Research Institute) have recently been estimated to account for an average increase in premiums of 4-5%.⁷ In addition to these fees, administrative requirements imposed by the PPACA on insurers and employers (e.g., reports on risk profiles and rating information, reporting requirements, benefit summaries, etc.) will also increase costs. For both fully-insured and self-insured plans, much of the administrative costs and taxes/fees will be passed on directly to members in the form of increased contributions/premiums.

Second, the PPACA has *required additional benefits and actuarial value* thresholds for insurance coverage that will make coverage more expensive compared to what a large share of employers (especially those buying coverage in the small group market) are able to provide today. The EHB requirements and the 60% AV are expected to increase premiums by an average of 11.5% to 25.5% across states. The cost impact varies considerably based on state-by-state differences in required benefits today.

Third, the PPACA provides for *guaranteed issue and community rating* (within 3-to-1 age bands that allow much less variation in premiums than are actuarially associated with age). While a limited number of states already have laws that substantially limit community rating and underwriting (and are generally also states that have individual insurance markets with low participation and high costs), the effect of this provision is likely to be substantial in the majority of states. The recent Milliman review finds premium increases of 20% to 45% on average in state individual exchanges.⁸

Fourth, it is likely that actual insurance cost and premium impacts will turn out to be even larger, depending on the extent of the “adverse selection” problem which will occur if healthier individuals choose not to enroll in coverage during the open enrollment period. Unfortunately, there are many reasons to believe that healthier individuals may enroll at a rate significantly lower than many of the model of exchange enrollment assume.

- Most people are not informed about what the PPACA’s new coverage options mean for them, and therefore, do not know what they need to do in order to participate. Even for those who want to enroll, choosing and enrolling in a plan is

⁷ O’Connor, James T. (Milliman, Inc.), “Impact of ACA Market Reforms on Affordability,” AHIP Policy Forum, April 2013.

⁸ Ibid.

likely to be difficult, especially if there is confusion about subsidy eligibility and the availability of reliable information from brokers, navigators, other assisters, and online or phone customer service systems. This could deter even more relatively healthy individuals from participating. These problems may be particularly acute in states where an FFE operates, since as of yet, outreach and enrollment support efforts have not yet come together.

- While the individual mandate or tax penalty serves as one reason to enroll, the financial implications are quite modest compared to the cost of insurance at least in the near term. As a result, individuals could choose not to enroll for completely rational reasons. For the foreseeable future, they may face only a small financial penalty, at most, if they do not enroll. Since there is no late enrollment penalty for those who find themselves later needing health care services and benefitting from coverage, waiting until they more clearly need coverage (especially if premiums seem high) is likely to be a reasonable decision for many.

In addition to these potential sources of cost and premium increases, some offsetting cost savings may result from PPACA implementation. These include tighter managed care and provider networks to keep costs down; pressure to use such networks is expected to be greater as a result of the new premium pressures. Competition among insurers in the non-group and small group market may also increase. The transitional subsidies for reinsurance and risk corridors may give insurers more confidence about offering plans with lower premiums and cost sharing. The recent Milliman review estimates these factors collectively could reduce costs by around 6% to 15%.

B. Summary of Impact Analyses

A variety of studies conducted by actuaries and academics have analyzed these new requirements and estimated the impact on insurance premiums on both the national and state level (See Appendix C).

For example, a study by Milliman considered the factors discussed above together and concluded that most individuals who buy non-group private insurance today will face significant premium increases in 2014. These increases will be particularly notable for younger, healthier individuals. Milliman estimates that individuals under age 35 will see premium increases that average between 19% and 35% (larger for males).

Studies in three different states estimate significant variation in premium increases, which may be attributed in large part to the different insurance requirements before the enactment of the PPACA:

- A study in Nevada estimated higher non-subsidized premiums in the non-group market of 11% to 30%, due primarily to the new EHB and AV requirements plus a shift to a less favorable risk pool.⁹

⁹ Gorman, B., Gorman, D., Smagula, J (Gorman Actuarial, LLC). Nevada Health Insurance Market Study (Prepared for the State of Nevada), March 2012.

- A study in Ohio predicts premiums will be 55% to 85% higher.¹⁰
- A study in Wisconsin estimates an average premium increase of about 39%.¹¹

Of course, the new income-related subsidies under the PPACA will offset the premium increases for many Americans purchasing coverage in the individual exchanges. However, the subsidies may do relatively little to encourage younger and relatively healthy individuals to participate in the insurance exchanges, given that their premiums are in effect subsidizing higher-risk participants. While certain small businesses with relatively low-wage workers are also eligible for a small business tax credit to help subsidize coverage, this credit also only covers a fraction of the costs and is limited in scope. Finally, providing subsidies for more costly coverage is not an effective way to address the fiscal implications of rising health care costs.

C. Need for More Extensive Impact Analysis for Small Businesses' Premium

For all these reasons, studies of the PPACA impact consistently show significant premium increases on average and very large increases for some individuals. The Solutions Council found less work has been done to analyze the impact that these changes will have on the premiums of coverage available to small businesses. This is a significant and concerning gap, because the Small Business Health Option Program (“SHOP”) exchanges and new insurance regulations may have a large impact on the millions of Americans who have historically received coverage through small businesses. Compared to studies on the premiums of plans offered in the individual insurance market, these studies generally show a similar impact of the new PPACA fees on insurance costs, a substantial but somewhat smaller impact of the new EHB and actuarial value requirements, and a substantial but somewhat smaller average impact from the changes in risk pools resulting from the guaranteed issue and community rating requirements for the small business exchanges. Nonetheless, these effects will be significant for millions of small business employees.

For example, in his recent review of the evidence on small business impact in the *Wall Street Journal* (April 30, 2013), Professor Daniel Kessler from Stanford noted an expected premium increase of 13% to 23% in premiums for the 15 million Americans covered by small business plans that do not self-insure. Moreover, small business owners will generally receive significantly smaller subsidies in the form of small business tax credits than individuals purchasing coverage on the individual exchange, meaning that employees and businesses will also experience these higher costs.

The effects on small businesses are expected to differ substantially from state to state and based on the employer's current coverage and risk profile. All of the analyses note that

¹⁰ Palmer, Jeremy, Jill Herbold, and Paul Houchens, “Ohio: Assist with the First Year of Planning for Design and Implementation of a Federally Mandated American Health Benefit Exchange,” August 2011, prepared for the Ohio Department of Insurance.

¹¹ Smagula, Jennifer, and Jonathan Gruber. “The Impact of the ACA on Wisconsin’s Health Insurance Market, July 2011, prepared for the Wisconsin Department of Insurance.

many small employers will face premium increases that are much larger than the average because their coverage was previously not as extensive as the PPACA requires and/or because of the impact of the likely shift in the risk profile in the small group exchanges.

For example:

- The Nevada study predicts little average effect on small group premiums, but 62% of employers in the small group market will see premium increases that average 14%.
- The Ohio study predicts small group premiums to rise by an average of 5% to 15%, with some firms having substantially larger increases.
- The Wisconsin study predicts that more than half of employers will see premium increases of 15% on average.

However, the impacts for particular small businesses may be much larger. For example, as Professor Kessler notes, premiums for firms with young, healthy workers in Nevada and other states are expected to double. The recent study by American Action Forum also finds that premiums for some small businesses will increase by 150% to 170%.

Because the Chamber remains concerned that the most substantial, short-term employer impact of these new insurance regulations is likely to be felt by small businesses, the Chamber is conducting further analyses on those impacts. The Chamber expects to release these results in the weeks ahead.

iv. Sudden and Uncertain Impact

All of these problems are particularly worrisome because every one of these major new regulatory changes is scheduled to be implemented suddenly, with no phase-in, in just a matter of months. As a result, not only is it likely that existing coverage will be disrupted for many employees, but large cost increases are likely to occur as well. These changes will make it even more difficult to encourage employees to purchase coverage, which is essential for a well-functioning insurance risk pool. In addition, PPACA implementation is leaving insufficient time for plans and issuers to assess what will be required under the final insurance market regulations and exchange landscapes. Many questions persist with regard to these final rules as well as key issues for the exchanges, further jeopardizing the availability of effective, affordable coverage options.

To avert the very real risk of large premium increases, coverage disruptions, and serious adverse selection problems throughout PPACA implementation, we propose a set of recommendations to help achieve the intended benefits of the law. We also propose a phase-in approach as noted above to enable more effective monitoring and adjustments to address any implementation problems that arise.

c. Principles and Proposals

• *Track Implementation and Assess the Impact on Premiums and Access*

The Federal government must start providing more complete implementation tracking metrics as soon as possible. These metrics should include, initially, some early indicators of the potential availability of different types of coverage options and their costs. For example, after initial filings are submitted in the spring, CMS should release information on the total number of plan filings, carriers, and plan levels (i.e., preliminary data by “metal” categories) at the regional level in both the individual and small group markets. No proprietary or plan specific information would be necessary. Subsequently, CMS must provide specifics as to plan availability, level, type and price well in advance of open enrollment which begins on October 1, 2013. Measures of plan enrollment (both overall and by plan and beneficiary categories) should be produced on a weekly basis when open enrollment begins.

As more finalized plan information becomes available, health plans should work with CMS to estimate the impact that three different factors are having on the premiums of existing plans. The three major contributors to changes in premiums at the plan level that should be assessed include:

1. Additional fees imposed by the PPACA, including estimates of overall administrative burdens and new taxes on health plans.
2. New benefit requirements, including EHB requirements and AV requirements.
3. New costs imposed by less favorable risk pools, including impact on premiums induced by guaranteed issue and community rating requirements, and not offset by broader participation. For example, this might include an estimate of the change in the risk profile of the insured population and its impact on average costs of coverage.

Analysis and reporting on the magnitudes of these impacts by state is particularly important if our proposal below to phase-in the insurance market reforms is not adopted. Health plans should not be subject to detailed rate review for the components of their premium increases that are directly attributable to the factors described above; such reviews will add unnecessary administrative burdens to PPACA implementation. The Chamber will continue to monitor and report on these issues related to the cost and availability of health insurance, particularly for their small business members.

• *Phase-in Insurance Markets Reforms*

Much of the serious potential for disruption of existing coverage and increased premiums could be mitigated by adopting a “phase-in” approach to the implementation of the new insurance market rules, particularly in cases where large premium increases would otherwise occur. While the Department of Health and Human Services (“HHS”) has

stated that they do not have authority to phase-in some of these new requirements on a national basis (most notably age-rating requirements), we believe that HHS does have substantial authority to do what is necessary to mitigate disruptions at a regional or market level. If plan bid information submitted in the spring suggests that large disruptions would otherwise occur (i.e., significant percent of filings represent significant premium increases of 15% or more), we urge HHS to adopt a phase-in implementation approach to stabilize the markets. These steps must be accompanied by a phase-in of the insurance plan rate review requirements as well. We strongly believe that HHS should also adopt these steps in the small business market, which is far more likely to suffer significant disruption and loss of existing coverage options in many states than the individual market. We are encouraged that HHS has already indicated its ability to take such steps, in response to a request from Massachusetts for a delay in the full implementation of the new requirements in its small business insurance market.

This transition plan could include:

- A phase-in of the community rating requirements;
- A phase-in of the minimum AV requirements (including deductible and out-of-pocket limits) for existing plans;
- A phase-in of the EHB requirements for existing plans;
- A phase-in of the rate review requirements for health insurance plans; and
- A phase-in of the reinsurance fee for a corresponding time period.

All of these steps would have to be looked at carefully and evaluated as to timeliness. These steps could also be implemented through legislation. The legislation would not need to address the core features of the PPACA. Instead, this specific legislation should focus on a phase-in to mitigate the major disruptions in coverage or costs that would occur otherwise and a phase-in of the financing provisions along with it, such as the reinsurance fee.

- ***Limit Adverse Selection***

Over the years, employers who provide health insurance have taken many steps to prevent adverse selection from harming the ability of their employees to access affordable coverage. However, many features of the PPACA in concert with the guaranteed issue and community-rating requirements jeopardize the likelihood that the healthier individuals needed for stable insurance risk pools will purchase coverage. If these healthier and younger individuals choose not to enroll, costs for employees and employers who have been acting responsibly to maintain their own coverage will increase significantly. In order to prevent this from happening, changes need to be made to:

- *Conduct more extensive outreach and education programs in collaboration with employers, including associations like the Chamber, to inform both employees and their employers about what the implementation of the PPACA means for them.* Providing such reliable and personalized information and implementation support is essential for achieving significant enrollment rates.
- *Discourage late or non-continuous enrollment in coverage.* Limiting open enrollment periods, supporting late enrollment penalties as in Medicare, and other steps that HHS has indicated states can undertake to address adverse selection should be a much more systematic part of the PPACA implementation plan, particularly in states with FFEs where HHS policies will be critical in determining the cost and take-up of coverage.
- *Reduce administrative burdens and costs that will be passed on to individuals in the form of higher premiums and consequently deter enrollment.* Elements that represent significant additional administrative costs include: the costs of data collection and submission for plans that participate in exchanges; substantial insurance exchange fees; and new taxes.
- *Permit low-cost coverage options* through reasonable flexibility in AV determinations. While coverage must provide sufficient protection for patients who need it, affordability is critical as well. Innovative coverage designs that have great promise for achieving both goals, including coverage with HSAs and value-based incentives, should be supported.
- ***Support High-Value, Prevention-Focused Coverage via Regulatory Actions and Legislation If Necessary***

The implementation of the PPACA now and in the future must build on the many successful innovative programs, benefit designs, and creative initiatives that businesses have incorporated in their health coverage offerings. As challenging as implementation will be, it is short sighted to simply focus on requiring employers to provide “affordable” coverage. The Solutions Council and the Chamber, along with other business groups, expect to continue to provide ideas for expanding access to high-value coverage, backed by concrete examples, both for large group and self-insured plans, as well as for plans offered in the small group and individual markets. While this will continue to encompass a wide range of specific issues, many of these recommendations fall into the following strategic approaches:

- *Allow flexibility in benefit design.* Concerns about adequacy of coverage should be addressed not by imposing new restrictions on such innovation, but by using performance measures that reflect better outcomes for beneficiaries in the health plans. While assuring that consumers can compare plans and have the protection they need against high health care costs, plans and issuers must have flexibility to continue to innovate and to:

- Develop benefit designs that build on provider network tiers;
- Allow co-pays to be set based on clinical value; and
- Provide flexibility as to how EHBs are provided to promote high-value health care (i.e., home-based or web-based alternatives to care as opposed to requiring that covered benefits are provided in a traditional, more costly setting).

As noted below, this flexibility should be provided in conjunction with monitoring of whether steps toward greater flexibility and innovation in benefit design are associated with lower quality of care for high-risk patients. For example, co-payments based on value (such as plans that pay a fixed amount toward the cost of an elective joint replacement) must be accompanied by meaningful quality measures showing that the “preferred” care and care providers are of high quality (i.e., showing that beneficiaries in the plan have access at low-cost to providers that achieve very low complications and very good functional results).

- *Permit incentives for wellness and consumer engagement to improve health and reduce costs.* Premium discounts, co-pay reductions, and other incentives that reward individuals for taking steps to improve their health should be encouraged. These approaches can be implemented on a non-discriminatory basis so that those people with more serious health problems have as many or more opportunities to save. HSAs and FSAs should be encouraged; these accounts protect individuals and employees from high medical costs while still enabling them to save money when they avoid unnecessary costs.
- *Promote transparency and flexibility in plan choice to enable employees to choose how to use their health care dollars, and work with employers to develop consistent measures of plan and provider quality.* We have described proposals for more effective transparency previously in this report; the implementation of the exchanges and insurance market reforms should be done in a way that supports these proposals. For example, quality measures in the exchanges should be consistent with those used by employers and in public insurance programs. Insurers are developing, and should be encouraged to continue to develop, ways to provide comparable information on the costs as well as the quality of different providers and treatments.
- *Assess consumers’ ability to make informed comparisons and choices, as well as quality of care when they are given greater flexibility in choosing designs and coverage options.* Greater flexibility should promote meaningful consumer engagement and higher-value care. It should not undermine the benefits of transparency or reduce quality of care. Better measures of the quality and cost of care and coverage, particularly for high-risk patients and patients with chronic diseases, will improve such assessments.

To achieve these goals, the Solutions Council believes that further steps can and should be undertaken administratively by HHS. We urge HHS to:

- *Allow more flexibility in the application of network requirements, EHB requirements after 2015, and other requirements for insurance plan design, so that plans can implement innovative approaches including value-based and tiered benefit plans;*
 - *Match these steps with increasing availability and monitoring of measures of quality of care in health plans, to help assure that the best combination of affordability and access is maintained;*
 - *Attribute employer contributions to HSAs and other financial supports for consumer-directed health plans entirely toward the AV of eligible health plans;*
 - *Permit greater flexibility to allow plans to apply reasonable out-of-pocket maximums and to consider employer HSA contributions when assessing the “effective” deductible of a HDHP;*
 - *Provide greater support and flexibility for wellness programs and other health promotion activities in large group and self-insured plans, as well as in the individual and small group insurance markets;*
 - *Minimize additional or special requirements for insurer participation in the FFEs or across different state-based exchanges (greater regulatory consistency will help reduce costs); and*
 - *Preserve the ability of employers to offer health care coverage through self-insurance and strong ERISA protection.*
- ***Encourage Greater Employment***
 - Revise the PPACA’s definition of full-time employee from 30 hours to 40 hours per week averaged over the course of a month. The PPACA’s change has already contributed to reductions in work hours. Returning to the widely accepted definition of a full-time employee as one who works an average of 40 hours per week would remove a penalty that is forcing employers to reduce hours, thereby limiting wages.
 - ***Enact Further Legislation to Make Health Insurance Exchanges Sustainable***

While we believe that much can be done under administrative discretion to support the availability of innovative, lower-cost coverage, we also support reforms that will require additional legislation. We encourage Congress to introduce legislation to:

- *Increase the availability of low-cost coverage options and continue to allow plans and issuers to offer existing coverage choices.* As we have noted, under current regulations, many employer plans with lower actuarial values and other features that have led to lower-cost coverage will be substantially restricted next year. While regulatory actions would help continue the availability of such plans, at least during a transitional period, legislation would provide even stronger support. At a minimum, employers should be able to continue to offer existing plans and employees should be able to continue to enroll in them without facing penalties or disincentives.
- *Take further steps to ensure participation.* The individual mandate will likely not enable competitive markets to work well for high-risk individuals. As noted above, HHS has identified steps that states can take to prevent the resulting adverse selection problems, such as limiting open enrollment periods, including late enrollment penalties, and other steps. Most importantly, the steps that we have outlined to reduce the cost of coverage will encourage many more people to buy insurance. If these steps are not implemented through regulation, they should be included in legislation.
- *Reduce fees that will translate into higher costs of insurance coverage, including the new taxes on many health care entities.* The budgetary impacts of reducing these fees and taxes should be offset by reducing the costs of implementing the PPACA. For example, the 3.5% tax on plans offered in FFEs could be offset by streamlining the data requirements and simplifying the process of plan participation, so that exchanges can be administered less expensively. Phasing in the PPACA requirements, as we have recommended above, would also help reduce costs.
- *Enable stronger consumer incentives to permit employers and plans to offer meaningful rewards for wellness and improving health.* As we have noted, employers now provide many incentives through HDHPs, wellness incentives, and other mechanisms for consumer engagement. While we believe that feasible regulatory actions could promote such patient engagement, legislation would ensure their availability and expansion. For example, legislation could relax the restrictions on employer financial incentives to reflect the financial incentives related to premium differences for smoking in the ACA (50 percent) and could enable health-related incentive programs so long as all employees regardless of health status have reasonable opportunities to participate and succeed. Such legislation could be accompanied by stronger requirements for quality and cost measures to assure that patients at higher risk or with chronic diseases are receiving effective care as a result of this increased ability to engage patients in care.
- *Increase permissible contribution levels for HSAs and FSAs and allow funds from tax-preferred accounts to be used to purchase long-term care insurance.*

- *Improve the coordination of the tax treatment for HSAs paired with HDHPs with other accounts and arrangements.* Such plans are increasingly popular and should be encouraged as an affordable way to provide access to needed care and to reward consumers for electing lower cost services, treatments and providers.

IV. REFORMING MEDICARE AND MEDICAID TO SUPPORT GREATER VALUE

a. Background

Most of this report has focused on policy reforms that directly affect the ability of business to obtain and provide high-value, efficient health care for their employees. However, Medicare and Medicaid have significant indirect effects on the quality and cost of care in the employer-sponsored system, as well. Since Medicare and Medicaid account for a large and growing share of health care costs, the way these programs pay providers and their benefits designs have a major impact on the way that care is delivered for all Americans. Perhaps less tangentially, Medicare affects employers that provide supplemental coverage to retirees receiving Medicare coverage. When employer-sponsored supplemental coverage wraps around Medicare, care is dictated and provided based on Medicare's design, which often leads to further cost increases and inefficiencies in coverage. Finally, while Medicare and Medicaid fill a critical role in providing coverage for older, disabled, and lower-income Americans, there are improvements that can and should be made to strengthen these entitlement programs for future generations.

Medicare is implementing some significant payment reforms, with the goal of better health, better care, and lower costs. Yet despite these efforts, Medicare's payments are still predominantly based on the volume and intensity of services, trailing behind many new payment models that employers are implementing. Even more significantly, Medicare is far behind most employers in implementing reforms that engage beneficiaries in better, more efficient care. Employers have designed benefits to enable enrollees to save more when they take steps to prevent disease and when they use less costly care. However, these initiatives are not incorporated at all in traditional Medicare or Medigap and severe restrictions have prevented MA plans from implementing such reforms. Medicare should do much more to implement reforms that follow successful models used by employers.

States should also receive more support from the Federal government to implement effective reforms in Medicaid to improve care and lower costs. Changes and improvements are more critical than ever, as many states expand their Medicaid coverage eligibility requirements to permit greater enrollment among more lower-income working adults, many of whom are or have been covered by employer plans. Medicaid coverage should be similar to effective coverage options offered by employers.

As part of these reform efforts, it is essential for Medicare and Medicaid to move away from securing short-term savings by simply reducing provider payment rates, often below the cost of providing the services. Instead, following employer models and other promising pilot programs, Medicare and Medicaid should identify ways to reward providers based on value, including through MA plans and approaches that have been developed in the private sector. Across-the-board Medicare and Medicaid reimbursement cuts do not improve care. Instead, these short sighted reductions only increasingly shift the costs of the care provided onto those employers and individuals who purchase private coverage. Alternatively, Medicare and Medicaid reforms should appropriately and

predictably compensate providers while moving the focus of payments and benefits to value. The private sector has increasingly implemented provider payment and benefits in MA plans and these effective alternatives should be adopted much more widely in public entitlement programs. This will give providers the certainty and support they need to make critical investments now to improve the delivery of care.

The nation's long-term fiscal outlook depends fundamentally on what happens with Medicare and Medicaid costs. Recent slowdowns in Medicare cost growth are somewhat encouraging and are expected to remain below the growth in gross domestic product ("GDP") per capita for the next few years. However, this by no means offers assurance that cost growth will continue to moderate and that Medicare will be able to sustain slower cost growth on a per-person basis in the future. In fact, under current law, Medicare's moderated cost growth reflects the kinds of reductions in physician payment rates and restrictions on prices to other health care providers that can threaten access to care and shift costs to employers rather than reduce costs overall. Even if per-capita spending growth remains low in Medicare, the demographics of the Baby Boom generation's retirement will cause further increases in Medicare spending. The problem is even more significant for Medicaid, which in recent years has been the fastest growing component of state budgets as a result of enrollment spikes and cost growth. Medicaid costs are projected to continue to increase as a share of federal and state spending, due to the PPACA eligibility expansions and enrollment growth.

The Solutions Council recognizes that a number of promising steps are underway in the Medicare and Medicaid programs. These include innovative care and disease management programs in MA, pilot value-based payment reforms in Medicare, some promising Medicaid waivers including expanded use of Medicaid managed care plans, and "dual-eligible" pilot programs to enable better financial alignment and care coordination for individuals eligible for both Medicare and Medicaid. However, the pace of these steps is not keeping up with the pace of reform in the private sector or with the urgent need for progress in reducing federal health care spending growth. Further, these modest entitlement improvements are not adequately aligned with innovative employer efforts to reform care. Consequently, the Solutions Council suggests specific recommendations as to how Medicare and Medicaid can: reinforce the promising steps that employers are taking; avoid cost-shifting; and contribute more effectively to needed health care reform.

The best way to accelerate needed reforms in the delivery and coverage of health care services for seniors and people with a disability is to engage them in the same way employers have engaged enrollees. Like many innovative employers, these entitlement programs should give beneficiaries more support for staying well and for preventing complications from their chronic conditions. This can be done by promoting a range of competing private health plan choices, through MA and reforms in traditional Medicare and Medigap, that provide better, more personalized support for beneficiaries' wellness and health. Most Medicare beneficiaries today are used to the traditional indemnity insurance that has been the core of traditional Medicare since 1965, and that coverage should not face major disruptions. However, younger beneficiaries have much more extensive experience with innovative insurance coverage. Medicare reforms should make

it much easier for these individuals to continue that type of innovative coverage when they turn 65, including the opportunity to save money when they obtain the coverage and care they need at a lower cost.

The best way to accelerate similar reforms in Medicaid is to use the same approach of promoting competing, innovative, efficient plans like those available through employer-sponsored coverage. Such innovative plan options could be provided through competition among Medicaid managed care plans, as well as among plans on insurance exchanges. With these steps, the opportunity exists for all Americans to have access to a competitive system that provides innovative, high-value coverage and passes along the savings to consumers.

b. Principles and Proposals

i. Medicare

Medicare and private insurance coverage must work together more seamlessly and effectively to promote better care and avoid unnecessary costs for both Medicare and private insurance beneficiaries. Several steps would accomplish this, while also improving Medicare's long-term fiscal outlook, by bringing long-term Medicare spending growth per beneficiary to a more sustainable level.

- ***Align Medicare with employer-sponsored and exchange coverage by permitting competition among coverage options.*** Medicare is not keeping up with the trend toward giving individuals choice and control over how they receive their health care benefits and services. It is important to adopt reforms in Medicare that would use competition to reduce cost growth, but allow continued innovation in delivery systems and advancements in care. Medicare Part D provides an effective model of innovative, low-cost coverage for seniors, by providing a subsidy that seniors use to choose among competing prescription drug plans. Many employers also enable employees to choose among competing health plans, and to save money when they choose lower-cost options that meet their needs. Especially with the modification we propose, the PPACA individual exchanges could enable individuals who do not receive coverage through their jobs to choose among competing insurance plans. If Medicare adopts the same approach for beneficiaries to choose among different ways of receiving their Part A and Part B benefits, most Americans would be able to select from competitive choices throughout their lives. This would support system-wide reforms in care that promote wellness and innovation in care delivery.
 - *Gradual transition toward a competitive choice option in Medicare* in which beneficiaries can spend a subsidy on the coverage and care that they prefer, as in Medicare Part D and the insurance exchanges while not disrupting care for current beneficiaries. This can occur through a *gradual transition* that might include pilots or demonstrations.
 - *Lower-income Medicare beneficiaries would continue to receive extra financial subsidies to help pay for their health care costs.*

- These reforms would not increase the financial risk facing individuals who develop very costly, serious illnesses. All Medicare plans would be required to provide protection against high health care costs, and Medicare could implement further initiatives for risk adjustment and reinsurance for high-cost individuals. Such reforms would enable better-targeted and therefore less costly protection for high-risk individuals than Medicare currently provides.
- ***Implement further provider payment reforms in traditional Medicare to reinforce the care and delivery innovations supported by the private sector.***
 - Payment reforms should promote higher value, instead of greater volume and intensity. This includes reforms that bundle payments at the level of care episodes and at the individual level, as in ACOs. These steps, along with the use of better performance measures implemented in a manner that continues to encourage the adoption of valuable new technologies, would give providers more flexibility to adopt innovative approaches to delivering care at the same or lower costs. Better performance measures would encourage higher quality and competition on value.
 - These payment reforms, which promote more accountability for value, should be accompanied by giving providers more timely and complete data on their patients to enable better care decisions.
 - Benefit reforms should accompany these payment reforms – a pairing that has been essential to the success of employer reforms in coverage, but that has generally been absent from Medicare payment reforms.
- ***Reforms in Medicare benefits and Medigap should enable beneficiaries to save through higher-value choices and wellness activities.*** The combination of Medicare's outdated benefit structure and Medigap currently creates challenges for beneficiaries to save money when they take steps to stay well, manage their chronic diseases, and choose higher-quality, lower-cost providers. Medicare beneficiaries traditionally have had a choice between buying only traditional Medicare coverage, under which they would face substantial and potentially unlimited out-of-pocket costs, or buying a Medigap plan which would reduce or eliminate these out-of-pocket costs across the board. In contrast, employer coverage gives individuals the opportunity to achieve substantial savings through premium and co-pay reductions when they take steps to stay well or use care effectively to avoid costs. The availability of recent Medigap options like "Plan N" represents a step toward giving beneficiaries more manageable and predictable out-of-pocket payments while still encouraging lower-cost care choices. Further steps to enable more value-based benefits in Medigap and MA plans, potentially accompanied by reforms in Medicare's co-pays and by establishing new catastrophic protection, would enable Medicare beneficiaries to save more when they choose high-value care. The Medicare Payment Advisory Commission ("Med-PAC") and many other groups have called for similar reforms. The Council recommends changes to:

- *Reform Medicare's benefit structure that provide better beneficiary protection and encourage more efficient use of care.*
 - *Enable beneficiaries to share in the overall Medicare savings from choosing lower-cost Medigap plans.* Currently, if beneficiaries choose lower-cost Medigap coverage like Plan N and, as a result, reduce their use of Medicare services, most of the savings go to Medicare. Consequently, beneficiaries have little financial incentive to choose Medigap plans that do not provide first-dollar coverage. Through either subsidies or penalties, beneficiaries could share in the overall Medicare savings (or costs) associated with their Medigap choice. This could be implemented prospectively, so that current Medicare beneficiaries can keep their existing plans without changes. This would encourage the development and update of value-based insurance design in traditional Medicare through Medigap.
 - *Remove barriers that prevent MA plans from offering value-based designs and wellness incentives, and enable plans to pass on savings to beneficiaries in lower premiums and co-pays.* Such value-based insurance designs and incentives are becoming key mechanisms for promoting better health and better care in employer coverage. Extending these to MA plans would provide additional momentum for needed reforms in care delivery.
 - *Provide higher-value extra assistance for low-income beneficiaries.* Low-income beneficiaries should continue to receive extra help through programs like Medicaid and the Part D Low-Income Subsidy program. These additional subsidies should also be updated to better support beneficiaries who choose lower-cost care and take steps to avoid costly complications, for example through further co-pay reductions.
- ***Enable Medicare to support private sector innovations in care.*** Medicare is implementing a number of payment reform pilots through the Center for Medicare and Medicaid Innovation (“CMMI”). However, most of these pilots are being implemented in Medicare alone. One exception is the multi-payer Advanced Primary Care Medical Home initiative. This initiative includes the use of meaningful, broadly-supported performance measures that should become increasingly sophisticated over time. By creating a more standardized way for Medicare to adopt multi-payer reforms that are being implemented in the private sector and states, Medicare’s pilot programs could have a much greater impact. Clearly the value of these patient centered approaches is substantial; they would not be supported by multiple employers if they did not improve quality and lower costs.
 - Medicare should develop a clear and straightforward path to participate in employer- and state-led multi-payer payment reform efforts focused on improving care delivery and health outcomes.
 - CMS should develop criteria to enable Medicare to participate in multi-payer payment reform efforts. For example, if a critical mass of private payers are involved and performance measures are included that are appropriate for Medicare beneficiaries, Medicare beneficiaries should be permitted to participate.

- Existing multi-payer pilots like the Advanced Medical Home initiative could be used to help create the more routine template and process. If these pilot reforms are effective, they could be expanded more widely in traditional Medicare.
 - If a critical mass of private payers has set up co-payment reductions or other steps for beneficiaries to share in the savings from lower-cost choices, providers should also be able to pass along these savings in a similar way to Medicare beneficiaries.
- ***Integrate Medicare and Medicaid coverage for dual-eligible beneficiaries.*** Beneficiaries eligible for Medicare and Medicaid have the greatest need for well-coordinated coverage, but often receive the most fragmented care because these traditionally fee-for-service entitlement programs are not well coordinated. Building on current pilot programs, dual-eligible coverage should move to health plans and bundled payments that combine Medicare and Medicaid funding to better integrate care. CMS and states should also provide better timely data support to the plans and providers that cover and treat dual-eligible beneficiaries enrolled in these programs. The reforms should include implementation and careful monitoring and evaluation of meaningful measures of quality and access to care, particularly for vulnerable beneficiaries, and should include continued access to key benefits such as Medicare Part D drug coverage. These reforms can be accomplished through MA plans, Special Needs Plans (“SNPs”), Medicare Social Health Maintenance Organizations (“Medicare Social HMOs”), Medicaid managed care plans, and other emerging dual-eligible pilots. States should be able to share significantly in the overall savings from these reforms through a process that includes better quality of care measurement and the gradual expansion of effective reforms. As lessons are learned from pilots and reforms, the potential disruption to beneficiaries’ access to care, services and benefits should be assessed and where appropriate addressed.
- ***Eliminate reliance on last-minute price reductions for Medicare providers, treatments, and Medicare Advantage plans.*** Again and again, Medicare payment rates are reduced. While it is important for Medicare to pay accurately, and while Medicare physician payment should be stabilized, meeting short-term budget goals through payment reductions can drive up utilization, prevent coordination of care, and may not reduce costs system-wide. Rather, these harmful cuts:
 - Promote cost-shifting to employers and beneficiaries in private plans;
 - Undermine private-sector reforms intended to improve care and promote innovation; and
 - Prevent providers from planning ahead and investing in innovative approaches to increase the value of care.

Similarly, large reductions in payments to MA plans destabilize coverage and undermine opportunities for system-wide reforms in care. The reforms we have

described here provide an alternative to Medicare's continued reliance on these hard-to-predict, short-term reductions in prices and problematic cost-shifting.

- ***Consider implementation of additional Medicare financing reforms to help improve Medicare sustainability.*** More needs to be done to address the sustainability of Medicare, and the program's ability to assure that high-quality coverage will be available in the future for the seniors and people with disabilities who depend on it. To meet this challenge, consideration should be given to a broad range of proposals, including such reforms as further means-testing of benefits and changes in eligibility ages. These types of financing and whole-sale programmatic proposals are not included in our report. Instead, our focus is on the entitlement reforms that are necessary to complement and reinforce effective reform steps that employers are undertaking. We believe that these reforms should be the foundation for further Medicare reforms.

ii. Medicaid

States should have more opportunities in Medicaid to adopt reforms that align with the private sector and provide better support for high-value care and disease prevention. With the new PPACA's Medicaid eligibility expansions, it is more important than ever to provide similar, if not seamless, coverage for lower-income individuals, regardless of whether they obtain their coverage through Medicaid or insurance exchanges. These steps will provide more momentum for reforms to improve health care delivery and health, rather than slowing needed system-wide reforms and shifting costs to employers.

- ***Encourage greater continuity between Medicaid, the exchanges, and employer-sponsored coverage by supporting greater availability of health plans that are similar to employer plans.***
 - Medicaid managed-care plans should have more flexibility to match the general features of private plans on the exchanges. A reasonable goal for low-income individuals whose eligibility shifts between Medicaid and the exchanges is to allow these individuals to keep the same or similar coverage, though lower out-of-pocket payments appropriate for individuals with lower income levels.
 - States should have more options for helping individuals with incomes above the federal poverty level ("FPL") access affordable, sustainable coverage. Many working individuals in the lower income range of approximately 100-150% of FPL may still not be able to pay even the limited premium contribution for the employer-sponsored coverage as required under the PPACA in 2014. CMS should work with states and employers to develop effective, competitive approaches for this population, accompanied by appropriate performance measures and limits on cost-sharing.
 - Currently states can assist Medicaid beneficiaries who have access to employer coverage by subsidizing the premium payment that the employer requires. This practice should be encouraged and facilitated.

- States should assure that Medicaid managed care plan payment rates are actuarially sound, so that up-to-date coverage for Medicaid beneficiaries is financially viable and costs are not shifted to employers.
- ***Support greater care coordination and address preventable costs for high-cost/high-risk Medicaid beneficiaries.***
 - Because states administer Medicaid, state investments in care coordination and other support for delivery reforms could be encouraged by enabling states to keep more of the savings when they achieve lower costs. However, savings must be achieved through better care-coordination and quality improvements, and not by reducing provider rates, which already fall well below the cost of providing the care, resulting in a cost-shift to employers.
 - For example, states currently receive an “enhanced match” for spending on information technology upgrades. The same approach could be applied to savings from better care.
- ***Continue Medicaid Disproportionate Share Hospital (“Medicaid DSH”) payments in states that do not expand Medicaid coverage.*** If these DSH payments are not continued, hospital uncompensated care will rise and employers will have to cover a larger share of the costs.
- ***Support multi-payer initiatives to improve care and lower costs.***
 - CMS and states should take further steps to promote the adoption of consistent quality measures in Medicaid that are based on widely used standards. For example, the National Committee for Quality Assurance (“NCQA”) has developed a widely-used set of quality measures for health plans, and the National Quality Forum (“NQF”) has endorsed a growing range of measures of provider quality. Using such measures whenever possible will reduce the administrative burdens of producing multiple quality measures, enable more meaningful comparisons of quality across states, and provide more support for multi-payer quality improvement initiatives.
 - As with Medicare, CMS should develop clear Medicaid templates and guidance to provide a much easier pathway for states to participate in multi-payer initiatives to reform payment and delivery. Existing regional and state multi-payer initiatives could be used as pilots and as a basis for developing such standard templates.
 - Multi-payer initiatives should also explore the consistent application of advanced analytic techniques, such as predictive modeling, to reduce improper payments and prevent fraud, waste and abuse.

CONCLUSION

As the country rapidly approaches the most critical stage of health care reform implementation yet, the policy proposals of the U.S. Chamber of Commerce's Health Care Solutions Council will be crucial in moving the nation toward health care reform that truly realizes greater value in the employer-sponsored health care system. In conjunction with the current reform efforts, these proposals have been carefully crafted to further address the need to control health care spending, address variation and disparity in access, cost and quality, and ease the law's burden on business and the public in the coming months. This report reflects the role that business has played, and will continue to play, in ensuring innovative employer practices pave the way for effective health care reform in 2014 and beyond.

These proposals represent the general consensus of the Solutions Council's member companies. A significant step has been taken by the Solutions Council members in compiling and highlighting the innovative approaches pioneered by employers in the private sector which can be pivotal in harnessing America's greatest potential to lead the way in modern health care reform.

The Chamber and the Solutions Council believe that leveraging the private sector initiatives currently underway and working towards the recommended modifications to the PPACA affecting private insurance, and employer coverage in particular, will help avoid disruptions and achieve greater value in health care during this implementation phase and as the nation tackles future health reform challenges.

APPENDIX A
MEMBERS OF HEALTH CARE SOLUTIONS COUNCIL

Abbott Laboratories
Aetna, Inc.
Buffalo Supply, Inc.
Caterpillar Inc.
Cigna Corporation
Comanche Home Center
The Dow Chemical Company
Duke University Health System
Eli Lilly and Company
Ford Motor Company
HCA Holdings, Inc.
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Johnson & Johnson Services, Inc.
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Strauss Surgical Group
TM Gorrie & Associates, LLC
UnitedHealth Group, Inc.
Verizon Communications, Inc.
Wegmans Food Markets, Inc.
WellPoint, Inc.
Womack Restaurants, an IHOP Franchisee

APPENDIX B **EXPERT SPEAKERS**

Joseph Antos, PhD, MA

Wilson H. Taylor Scholar in Health Care and Retirement Policy
American Enterprise Institute

The Honorable Max Baucus, JD

U.S. Senator from Montana
Chairman of the Senate Finance Committee

Mike Chernew, PhD

Professor of Health Care Policy
Department of Health Care Policy
Harvard Medical School

Dan Crippen, PhD, MA

Executive Director
National Governors Association

Doug Hastings, J.D.

Chair of the Board of Directors
Epstein, Becker & Green, P.C.

Mark McClellan, MD, PhD, MPA, MA

Director of the Engelberg Center for Health Care Reform
Leonard D. Schaeffer Chair in Health Policy Studies
Brookings Institution

Arnold Milstein, MD, MPH

Professor of Medicine and Director
Clinical Excellence Research Center
Stanford University

Uwe E. Reinhardt, PhD

James Madison Professor of Political Economy
Professor of Economics and Public Affairs
Princeton University

Alice Rivlin, PhD

Senior Fellow, Economic Studies Program
Brookings Institution

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Senior Fellow
Hudson Institute

APPENDIX C
PREMIUM IMPACT CHART

<i>Study</i>	<i>Average impact on premiums for small & large employers</i>	<i>Distribution of Employer Impact</i>	<i>Reasons for Impact on Employers</i>
American Action Forum (January 2013)	Report analyzed distribution across age/health groups and did not report average overall effects on premiums	<p>Small Group Market:</p> <p>Younger & Healthier workers*: Average Increase 149%</p> <p>Chicago, IL: increase by 144% Phoenix, AZ: increase by 134% Atlanta, GA: increase by 148% Austin, TX: increase by 141% Milwaukee, WI: increase by 176%</p> <p>Older, less healthy workers**: decrease 26%</p> <p>Chicago, IL: decrease by 26% Phoenix, AZ: decrease by 26% Atlanta, GA: decrease by 31% Austin, TX: decrease by 24% Milwaukee, WI: decrease by 24%</p>	Elimination or constraint of age, health status, and gender rating factors

* Younger, healthy defined by non-smoking, 27 year old

** Older, less healthy defined by smoking, 55 year old

<i>Study</i>	<i>Average impact on premiums for small & large employers</i>	<i>Distribution of Employer Impact</i>	<i>Reasons for Impact on Employers</i>
State Compendium (Milliman)			
Alaska (2012)	<ul style="list-style-type: none"> small group market average increase of 1.1% 		<ul style="list-style-type: none"> enhanced benefits to meet actuarial value replacement
Connecticut (2012):	<ul style="list-style-type: none"> small group market average increase by overall by 11% 		<ul style="list-style-type: none"> medical trend, required increases in benefits covered, new taxes and assessments combine to increase premiums by 29%; changes in demographics, average morbidity of those enrolled and benefit buy-downs made by employers lead to a decrease in premiums of roughly 14%
Maryland (2011)	<ul style="list-style-type: none"> average small group premium increase by 2% 	<ul style="list-style-type: none"> 62% of small group market expected to experience an average of 14% increase; 38% of market expected to experience an average of 17% decrease in their premiums 	<ul style="list-style-type: none"> small group market already mirrors many of the ACA's requirements with respect to essential health benefits and expected to have relatively stable risk pool
Nevada (2012)			<ul style="list-style-type: none"> increase due to elimination of health underwriting; premiums may increase approximately 0.5% on average due to essential health benefits and actuarial value requirements & 10% of market may experience an average premium increase of 7% due to minimum actuarial value requirements
Oregon (2012)	<ul style="list-style-type: none"> premiums in small group market are projected to increase by 3% 		<ul style="list-style-type: none"> individual firm behavior and current group risk composition could produce premium increase as much as 14% for some and decreases as large as 5%

			<ul style="list-style-type: none"> •
<i>Study</i>	<i>Average impact on premiums for small & large employers</i>	<i>Distribution of Employer Impact</i>	<i>Reasons for Impact on Employers</i>
Indiana (Milliman, May 2011)	<ul style="list-style-type: none"> • Estimated premium rate change for small group insured market beginning in 2014: increase 5% to 10% 		<ul style="list-style-type: none"> • Risk pool composition changes occurring because employers terminating their sponsored health plans, individuals with non-qualified coverage entering the individual market, the inclusion of employers with up to 100 employees in the small group market, and employers electing to self-fund their sponsored health plan, rather than stay in the insured market, elimination of high risk pool assessments, manufacturer and carrier fees pass-throughs, and provider cost shifting • Premium increase less pronounced because small group plans in IN more likely to already cover the Essential Health Benefits

<i>Study</i>	<i>Average impact on premiums for small & large employers</i>	<i>Distribution of Employer Impact</i>	<i>Reasons for Impact on Employers</i>
Maine (Gruber, May 2011)	<ul style="list-style-type: none"> Estimated premium rate for small group market: estimated increase of 12% 	<ul style="list-style-type: none"> 89% of small employer groups will experience an average premium increase of 12% 11% of small employer groups will have an average of 17% decrease 12,000 Maine residents will lose their ESI (2% decline) 	<ul style="list-style-type: none"> Elimination of carrier's ability to use group size adjustments and the impact of the introduction of the health insurance marketplace and its influence on a small number of employers to drop coverage

<i>Study</i>	<i>Average impact on premiums for small & large employers</i>	<i>Distribution of Employer Impact</i>	<i>Reasons for Impact on Employers</i>
Minnesota (Gruber, January 2013)	<ul style="list-style-type: none"> No change 		<ul style="list-style-type: none"> Managed care competition
Ohio (Milliman, August 2011)	<ul style="list-style-type: none"> Estimated ESI-small group market premiums: increase by 5% to 15% Estimated ESI-large group market premiums: increase by 3% to 5% 		<ul style="list-style-type: none"> Small group market: Primarily driven by the estimated health status of the remaining ESI-small group market, ACA-imposed insurance carrier fees, and provider cost shifting from the public programs. Additionally impacted by adjusted community rating which may increase the level of adverse selection within the market and contribute to market premium increases. Large group market: Primarily driven by the ACA-imposed carrier fees and provider cost shifting from the public programs

Study	Average impact on premiums for small & large employers	Distribution of Employer Impact	Reasons for Impact on Employers
Wisconsin (Gruber, July 2011)		<ul style="list-style-type: none"> • 53% of small employer groups: average premium increase will be 15% • 47% of small employer groups: average premium decrease of 16% 	<ul style="list-style-type: none"> • Elimination of carrier's ability to use health status as a rating variable and elimination of group size adjustments

References:

1. Herbold, Jill. And Paul Houchens (Milliman Inc.), "Indiana: Individual and Small Group Premium Changes Under the ACA," May 2011. *Prepared for by the Indiana Health Care Exchange Policy Committee.*
2. Holtz-Eakin, Douglas. "Insurance Premiums in 2014 and the Affordable Care Act: Survey Evidence," American Action Forum, January 2013.
3. Palmer, Jeremy and Jill Herbold and Paul Houchens, "Ohio: Assist with the First Year of Planning for Design and Implementation of a Federally Mandated American Health Benefit Exchange," August 2011. *Prepared for the Ohio Department of Insurance.*

4. "Research Findings: Independent Studies Estimate the Cost and Coverage Impact of the Affordable Care Act in Selected States," (Milliman, Inc.), Americans Health Insurance Plan, December 2012.
5. Smagula, Jennifer and Jonathan Gruber, "Maine: The Impact of the ACA on Maine's Health Insurance Market," May 2011. *Prepared for the Maine Bureau of Insurance*.
6. Smagula, Jennifer and Jonathan Gruber, "The Impact of the ACA on Wisconsin's Health Insurance Market," July 2011. *Prepared for the Wisconsin Department of Health Services*.