Health Insurance Premiums Under the Affordable Care Act

by

Daniel T. Durham
Executive Vice President, Policy and Regulatory Affairs
America's Health Insurance Plans

for the
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I. Introduction

Chairman Murphy, Ranking Member DeGette, and members of the subcommittee, I am Dan Durham, Executive Vice President for Policy and Regulatory Affairs at America's Health Insurance Plans (AHIP), which is the national trade association representing health insurance plans. AHIP's members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. AHIP advocates for public policies that expand access to affordable health care coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation.

We appreciate this opportunity to testify on the impact the Affordable Care Act (ACA) will have on health insurance premiums in 2014. Our members are strongly committed to competing in the new Exchanges and offering high quality, affordable coverage options under the framework established by the new health reform law. At this stage of the ACA implementation process, many of our members already have submitted applications for qualified health plans (QHPs) they will be offering in the federally-facilitated health insurance Exchanges in 2014. Others have or are preparing to offer coverage in the state-based Exchanges, state partnership Exchanges, and in the outside market. All across the nation, our members are working hard to provide value to individuals and families, employers, and beneficiaries in government programs.

Our members are focused on implementing all of the new changes required by the ACA in 2014 in a manner that will be least disruptive and least costly for consumers and employers, and we have been working closely with federal and state regulators to identify challenges and offer constructive solutions. Health plans are committed to ensuring implementation is as smooth as

possible and are doing their part to be ready to go when open enrollment begins. Companies have dedicated teams working around the clock to implement all of the changes, and we will continue to work constructively with federal and state regulators.

Our testimony today will focus on two broad areas:

- Factors that are driving health insurance premiums, including specific provisions of the ACA and underlying medical costs; and

- Strategies we support for bringing down health care costs and our participation in a diverse stakeholder group that has developed recommendations for decelerating health care costs and improving quality.

II. Factors Driving Health Insurance Premiums

A broad range of studies, including several commissioned by AHIP, provide insights into the likely impact the ACA will have on health insurance premiums beginning in 2014. Additional studies examine the role that underlying medical costs play in increasing the cost of coverage.

Comprehensive Analysis of ACA by Milliman

In late April, AHIP released a report[1] from Milliman that provides a comprehensive overview of ACA provisions that will impact individual market health insurance premiums in 2014. This

[1] Milliman, Comprehensive Assessment of ACA Factors That Will Affect Individual Market Premiums in 2014, April 25, 2013

study highlights how some provisions will increase premiums while others will make coverage more affordable.

The Milliman report explains that covering pre-existing conditions, requiring a broader benefit package, and covering uninsured Americans who have gone without medical care will benefit millions of people while increasing the cost of health care coverage. It further emphasizes that the new health insurance tax and other fees will also increase premiums. At the same time, Milliman indicates that other ACA provisions will make coverage more affordable, including premium and cost-sharing subsidies and the transitional reinsurance program, which provides funds to help offset the impact of high-cost enrollees.

The impact on specific individuals will vary significantly depending on their age, gender, location, health status, income level, and what coverage they have today. The Milliman report found that "young, healthy males could see substantial increases due to the combination of the overall rate change and the age/gender rating requirements" while "older, less healthy individuals could see rate reductions."

Individuals and families with household incomes up to 400 percent of the federal poverty level (FPL), or approximately $94,200 for a family of four or $45,960 for an individual, will be eligible for financial assistance to help lower total out-of-pocket insurance costs. The Milliman report estimates that those eligible for subsidies will receive financial assistance in 2014 to cover, on average, 40 percent of the premium for the "Silver" plan, and as much as 94 percent for those with the lowest incomes. "Bronze" plan premiums after the subsidy could be as low as $0 for certain low-income individuals.

The report also notes that millions of people will not be eligible for subsidies and that the amount of the subsidy declines significantly as incomes rise. The Congressional Budget Office (CBO) estimates that persons with incomes between 250-300 percent of the FPL will receive subsidies sufficient to cover 42 percent of their premium and those with incomes between 350-400 percent of the FPL will receive assistance to coverage 13 percent of the premium.

Milliman explains that new innovative benefit designs developed by health plans will lead to more affordable coverage options than would otherwise be available. These include wellness programs that encourage healthy living, prescription drug formularies that incentivize patients to choose lower-cost generic drugs when they are available, and the availability of "high-value networks" that are limited to providers with a track record of providing the highest quality care at the lowest cost.

The report also highlights the importance of bringing younger and healthier people into the system to help keep coverage as affordable as possible. Milliman states: "When faced with high premiums, younger and healthier individuals may choose to forgo purchasing health insurance until they need it, which will only serve to increase costs for all other individuals in the healthcare system… For the individual insurance market risk pool to remain stable in 2014 and beyond, it is vital that young and healthy individuals enter and remain in the insurance market in addition to individuals with an immediate need for healthcare services."

Focusing on numerous aspects of ACA implementation that will impact premiums, the Milliman report includes the following estimates:

- **Health Insurance Tax:** The ACA's new health insurance tax is estimated to increase premiums in 2014 by about **2 percent** on average.

- **Exchange User Fees:** The user fee that applies to insurers participating in the federally-facilitated Exchanges is estimated to increase premiums by an average of **1.4 percent**. Although the user fee is set at 3.5 percent, the estimate by Milliman is based on insurers selling coverage both inside and outside of the Exchanges.

- **Transitional Reinsurance Assessment:** The fee to support the ACA's transitional reinsurance program is estimated to increase premiums for all consumers by an average of **1 to 2 percent**. However, the subsidy the transitional reinsurance provides in the individual market for high cost claims is estimated to reduce premiums for consumers in the individual market by **6 to 12 percent**.

- **Benefit Buy-Up:** Beginning in 2014, the ACA will require health plans to provide coverage for an essential health benefits (EHB) package covering a broad range of mandated benefits, some of which typically are not included in current individual and small group policies. As noted in the Milliman report, individuals will receive more comprehensive benefits which could reduce out-of-pocket costs, but at a higher pre-subsidy premium level. Milliman estimates that the EHB requirements will increase premiums in the range of **3 to 17 percent**. Additional studies, requested by various state departments of insurance and state Exchange boards, also have found that the EHB requirements will result in higher premiums.

- **Minimum Actuarial Value Requirement:** The ACA requires that coverage sold through the new Exchanges must be at one of four actuarial value levels: 60% (Bronze); 70%

(Silver); 80% (Gold); and 90% (Platinum). Most people will be required to buy coverage with a minimum actuarial value requirement of at least 60 percent (i.e., the "Bronze" plan). Milliman notes that a study[2] recently published in *Health Affairs* estimates that this requirement will increase premiums by an average of **8.5 percent**.

- **Age Rating Restrictions:** Beginning in 2014, the ACA will allow heath insurance rates to vary, based on an enrollee's age, by a ratio of no more than 3 to 1 (3:1). This is a dramatic change from the **"age bands"** of 5 to 1 (5:1) or more that are currently effective in 42 states where state policies recognize that utilization of health care services is correlated with age and that health insurance only works if younger and healthier consumers are part of the risk pool. These states, relying on decades of expertise in setting rules that balance the needs of different age groups, provide protection to older consumers without making coverage unaffordable for younger consumers. We are deeply concerned that the ACA's restrictive age band, by overriding these state policies, will cause premiums to increase dramatically for younger people. Milliman estimates that the new age rating restrictions will increase premiums for people under the age of 35 by **19 to 35 percent**, while reducing premiums for people age 55 and older by **4 to 9 percent**. Similarly, a study conducted by Oliver Wyman found that young, single adults aged 21 to 29 and with incomes beginning at about 225 percent of the federal poverty level, or roughly $25,000, can expect to see higher premiums than would be the case absent the ACA – even after accounting for premium subsidies.[3] As a result, this issue may have implications for the broader population of health care consumers. If higher premiums cause younger and healthier people to delay purchasing coverage until

[2] Gabel, J. et al. (2012). More Than Half Of Individual Health Plans Offer Coverage That Falls Short Of What Can Be Sold Through Exchanges As Of 2014, *Health Affairs* 31 No. 6

[3] Kurt Giesa and Chris Carlson. "Age Band Compression under Health Care Reform." *Contingencies;* Jan/Feb 2013.

after they are sick or injured, the overall pool of people purchasing health insurance will be weighted more heavily with older and less healthy people – thereby driving up premiums for everyone and destabilizing the market. Reps. Phil Gingrey (R-GA) and Jim Matheson (D-UT) have introduced bipartisan legislation, H.R. 544, which addresses this concern by allowing states to set their own age rating rules and by establishing a 5:1 age rating band in states that do not take action.

- **Changes in Risk Pool Composition / Adverse Selection:** Milliman notes that the ACA will result in many people entering the individual health insurance market, including those who previously were uninsured and who were enrolled in state high-risk pool programs or the Federal Preexisting Condition Insurance Plan (PCIP) program. The entrance of these new enrollees into the market will impact premiums because their average health status differs from that of current enrollees in the individual market. Milliman also discusses several additional factors – including the ability of consumers to choose plans based on their expected health needs, and the elimination of underwriting and preexisting condition exclusions – that will lead to adverse selection. Overall, Milliman estimates that changes in the composition of the risk pool and adverse selection will cause premiums to increase by **20 to 45 percent**.

- **Pent-Up Demand:** Milliman estimates that as the uninsured gain health coverage in 2014, there will be a temporary surge in the utilization of health care services by people seeking preventive care or treatment for minor health issues for which they otherwise would not seek medical care. Milliman estimates that this will cause premiums to increase by **up to 5 percent**.

- **Market Competition:** Milliman estimates that market competition in the new Exchanges will reduce premiums by **0 to 5 percent**.

- **Innovation in Benefit Design:** New innovative benefit designs developed by health plans will lead to more affordable coverage options than otherwise would be available. These include wellness programs that encourage healthy living; prescription drug formularies that incentivize patients to choose lower-cost generic drugs; and the availability of high-value networks. Milliman estimates that these innovative strategies could reduce premiums by up to **10 percent**.

- **Premium Assistance Tax Credits:** Milliman estimates that the ACA's premium assistance tax credits will cover, on average, about **40 percent** of the "Silver" plan premium in 2014 in the individual market. As we noted earlier, Milliman estimates that premium subsidies for those eligible would cover about 40 percent of the cost of "Silver" plan coverage – a substantial benefit that will make coverage more affordable. At the same time, according to the Congressional Budget Office, more than 40 percent of individuals purchasing individual market coverage are not eligible for subsidies and the generosity of the subsidies scales back significantly for moderate-income families.

- **Catastrophic Plans:** The ACA allows for the availability of "catastrophic plans" to individuals under the age of 30 and anyone who is exempt from the individual mandate due to lack of affordable coverage options. Catastrophic plans are intended to provide lower premiums and more affordable coverage options – particularly for price-sensitive, younger adults. Milliman estimates that premiums for catastrophic plans will be lower than those available for "Bronze" plans.

The findings of the Milliman report are reinforced by studies conducted by other research organizations, including the American Academy of Actuaries and the Society of Actuaries.

A May 2013 issue brief[4] by the American Academy of Actuaries identifies several factors that will determine premium levels in 2014: the effectiveness of the individual mandate and premium subsidies at attracting low-cost enrollees into the insurance market; new benefit requirements that may lead to higher premiums but lower out-of-pocket costs; decisions by employers about whether to continue offering coverage and the health status of employees whose coverage is dropped; how each state's current market rules compare to the ACA reforms that take effect in 2014; and the demographic characteristics and health status of consumers purchasing coverage through the new Exchanges.

A March 2013 report[5] by the Society of Actuaries concludes that changes driven by the ACA could increase underlying claims costs in the individual market by an average of 32 percent nationally by 2017. This report also predicts wide variation across the states, with as many as 43 states experiencing a double-digit increase in claims costs.

The New ACA Health Insurance Tax

The health insurance tax established by the ACA – which we mentioned above in our review of the Milliman report – is scheduled to begin in 2014 and will exceed $100 billion over the next ten years. The tax is set at $8 billion in 2014, $11.3 billion in 2015 and 2016, $13.9 billion in

[4] American Academy of Actuaries, How Will Premiums Change Under the ACA?, May 2013
[5] Society of Actuaries, Cost of the Future Newly Insured under the ACA, March 2013

2017, and $14.3 billion in 2018. In subsequent years, the tax will increase annually based on premium growth.

The health insurance tax will be imposed broadly on health insurance providers, based on their market share, and will impact the following: (1) businesses and public employers that purchase health insurance on a fully insured basis, including small businesses that provide coverage; (2) all individuals and families who purchase coverage in the individual market or through an Exchange; (3) Medicare beneficiaries who enroll in Medicare Advantage health plans or Medicare Part D prescription drug plans; and (4) state Medicaid programs that contract with managed care organizations.

While the ACA health insurance tax is assessed on health plans, experts agree that it will impact consumers and employers that purchase coverage directly from health insurance plans in the individual and group markets as well as beneficiaries in public programs. The Congressional Budget Office (CBO) has stated that this tax will be "largely passed through to consumers in the form of higher premiums."[6]

The magnitude of the expected premium increase is addressed by a pair of actuarial studies that have been conducted by the Oliver Wyman firm and commissioned by AHIP. The first study[7] examined the impact the premium tax will have – from a nationwide perspective – on individual

[6] CBO letter to Sen. Even Bayh. "An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act." 30 November 2009.
[7] Carlson, Chris. "Estimated Premium Impacts of Annual Fees Assessed on Health Insurance Plans." Oliver Wyman. October 2011.

market consumers, employers, Medicare Advantage enrollees, and state Medicaid programs. A second study[8] provides state-by-state data on the impact of the tax in all 50 states.

The Oliver Wyman analysis concluded that the health insurance tax alone will increase the cost of family coverage in the individual market by $270 in 2014 and by an average $5,080 over the ten-year period of 2014-2023. The study also estimated that the health insurance tax will increase the cost of family coverage in the small group market by $360 in 2014 and by an average of $6,830 over the same ten-year period. These findings are reinforced by Congress' Joint Committee on Taxation (JCT)[9], which has estimated that repealing the health insurance tax could decrease the average family premium in 2016 by $350 to $400.

The health insurance tax is particularly burdensome not only because of its size, but also because it is not deductible for income tax purposes. This means that health plans must pay the tax and then also pay federal, state, and local taxes on the taxed amount. The Oliver Wyman study notes that because the ACA health insurance tax is not deductible, the potential impact of the tax on premiums will be $1.54 for each $1.00 paid toward the tax by insurers.

Focusing specifically on the Medicare Advantage (MA) program, the Oliver Wyman study found that the health insurance tax will increase costs for MA enrollees by $16 to $20 per month in 2014 and by $32 to $42 per month by 2023. The average expected increase in the cost of MA coverage over ten years is $3,590. This number represents a direct reduction in the resources that will be available to support the health care benefits of 14 million seniors and persons with disabilities who value the improved quality of care, additional benefits, and innovative services

[8] Carlson, Chris. "Annual Tax on Insurers Allocated by State." Oliver Wyman. November 2012.
[9] See JCT Letter to Senator Jon Kyl. 12 May 2011.

their MA plans provide. Additional costs will be imposed on Medicare Part D plans, for which the health insurance tax will increase premiums by an estimated $9 in 2014 and $20 in 2023 for a total increase of $161 over 10 years.

We also are deeply concerned by estimates in the Oliver Wyman study that the health insurance tax will put greater pressure on state Medicaid budgets by increasing the average cost of Medicaid coverage by an estimated $1,530 per enrollee between 2014-2023. In several states (see chart on next page), the impact on the cost of Medicaid coverage will exceed $2,200 per enrollee over ten years. Taking such a significant level of resources away from Medicaid at a time when many states are implementing major expansions in Medicaid eligibility is a shortsighted move that may compromise access to health care services for millions of vulnerable people.

Oliver Wyman's state-by-state findings provide additional information showing which states will be most severely impacted by the ACA health insurance tax. The charts below highlight the top 20 states with the highest per-person cost impact in each market segment. These charts show, for example, that families purchasing coverage in the individual market will be hit the hardest in New York while those getting coverage from a small employer will be most impacted in West Virginia. With respect to public programs, Medicare Advantage enrollees in New Jersey and the Medicaid managed care program in Washington, DC will be hardest hit by the new tax.

Individual Market

Top 20 States with Highest Average Aggregate Impact of Health Insurance Tax on Family Coverage Purchased in the Individual Market (2014 - 2023)

#	State	Ten-Year Impact (per family)
1	New York	$9,942
2	Massachusetts	$9,937
3	Rhode Island	$8,308
4	Connecticut	$6,339
5	New Hampshire	$5,736
6	Georgia	$5,539
7	Maine	$5,429
8	Minnesota	$5,245
9	District of Columbia	$5,187
10	Delaware	$5,007
11	Wisconsin	$4,961
12	California	$4,909
13	Florida	$4,881
14	Alaska	$4,855
15	West Virginia	$4,844
16	Washington	$4,843
17	Texas	$4,833
18	New Mexico	$4,805
19	New Jersey	$4,796
20	Pennsylvania	$4,772
20	Virginia	$4,772

Small Employers

Top 20 States with Highest Average Aggregate Impact of Health Insurance Tax on Family Coverage Offered Through Small Employers (2014 - 2023)

#	State	Ten-Year Impact (per family)
1	West Virginia	$9,221
2	New York	$9,046
3	New Hampshire	$8,555
4	Nebraska	$7,995
5	Massachusetts	$7,895
6	District of Columbia	$7,613
7	Connecticut	$7,454
8	Rhode Island	$7,414
9	Delaware	$7,345
10	Illinois	$7,293
11	Florida	$7,136
12	Alaska	$7,124
13	New Mexico	$7,051
14	New Jersey	$7,038
15	Colorado	$7,005
16	Maryland	$6,985
17	Texas	$6,971
18	Wyoming	$6,960
19	Wisconsin	$6,932
20	California	$6,916

Medicare Advantage

Top 20 States with Highest Average Aggregate Impact of Health Insurance Tax on Medicare Advantage Beneficiaries (2014 - 2023)

#	State	Ten-Year Impact (per person)
1	New Jersey	$4,182
2	Florida	$4,181
3	Louisiana	$4,111
4	New York	$4,074
5	Texas	$4,033
6	Maryland	$4,022
7	Massachusetts	$3,962
8	District of Columbia	$3,919
9	Connecticut	$3,895
10	California	$3,847
11	Michigan	$3,838
12	Mississippi	$3,746
13	Illinois	$3,728
14	Pennsylvania	$3,708
15	Delaware	$3,660
16	Ohio	$3,618
17	Rhode Island	$3,555
18	Tennessee	$3,523
19	Oklahoma	$3,513
20	Indiana	$3,458

Medicaid Managed Care

Top 20 States with Highest Average Aggregate Impact of Health Insurance Tax on Medicaid Managed Care Programs (2014 - 2023)

#	State	Ten-Year Impact (per person)
1	District of Columbia	$2,518
2	New York	$2,466
3	Rhode Island	$2,360
4	New Jersey	$2,276
5	Minnesota	$2,257
6	Massachusetts	$2,219
7	North Dakota	$2,093
8	Pennsylvania	$2,038
9	Maryland	$2,026
10	New Hampshire	$1,921
11	Missouri	$1,790
12	Wisconsin	$1,789
13	Wyoming	$1,763
14	Kansas	$1,748
15	Oregon	$1,727
16	Ohio	$1,685
17	Nebraska	$1,671
18	Delaware	$1,637
19	Kentucky	$1,622
20	New Mexico	$1,615
20	Virginia	$1,615

To avoid the increased costs that would result from the ACA health insurance tax, we strongly support legislation, H.R. 763, which would repeal the tax. This bipartisan bill, the "Jobs and Premium Protection Act," was introduced in February 2013 by Reps. Charles Boustany (R-LA) and Jim Matheson (D-UT). To date, 182 House members have cosponsored this bill, including 27 members of the House Energy and Commerce Committee.

Underlying Medical Costs

Additional challenges are raised by the underlying costs of medical care, which are driving up the cost of coverage, taking up a greater share of federal and state budgets, and threatening the long-term solvency of our nation's public safety net programs.

A September 2012 study[10] by the Health Care Cost Institute found that "higher prices were the primary driver of per capita health spending in 2011." This study found that unit prices increased by 9.7 percent for outpatient surgery, 9.1 percent for emergency room visits, 7.4 percent for mental health and substance abuse admissions, 6.5 percent for surgical admissions, and 6 percent for deliveries and newborns.

Another study[11], published by the *American Journal of Managed Care,* provides new data on trends in hospital prices across the country. This study, conducted by researchers at AHIP, found that from 2008 to 2010 inpatient hospital prices increased 8.2 percent annually, while also highlighting common medical procedures that experienced the highest growth in prices during the period studied. Overall, the price for a spinal fusion increased the most (15.2 percent annually) between 2008 to 2010. The next highest price increases were for bronchitis and

[10] Health Care Cost Institute, Health Care Cost and Utilization Report: 2011, September 2012
[11] AJMC.com, Trends in Inpatient Hospital Prices, 2008 to 2010, March 6, 2013

asthma treatment (10.3 percent annually) and uterine laparoscopic procedure for non-malignancy (9.8 percent annually).

Our study also found wide variation in hospital prices across states and localities. Among the states examined by this study, New York experienced the largest increase in hospital prices from 2008 to 2010 (10.5 percent annual growth). Texas (9.3 percent annual growth) and Tennessee (8.8 percent annual growth) also saw higher-than-average increases in hospital prices. Hospital prices also varied significantly among metropolitan areas within a state.

Another AHIP study[12] highlights the exorbitant fees that some out-of-network physicians are charging for services. This study found that some physicians who choose not to participate in health insurance networks are charging patients fees that are 10 times – and in some cases, close to 100 times – Medicare reimbursement for the same service in the same geographic area. The following are just a few examples of the unreasonable charges consumers sometimes face when receiving care from out-of-network providers:

- $19,000 for a colonoscopy and biopsy – 33 times more than Medicare pays;

- $29,998 for an upper GI endoscopy biopsy – 73 times more than Medicare pays; and

- $12,000 for a tissue exam by a pathologist – 93 times more than Medicare pays.

In addition to showing how much patients who seek out-of-network care are being charged by some physicians, these findings also illustrate the value of the physician networks that are

[12] AHIP, Survey of Charges Billed by Out-of-Network Providers: A Hidden Threat to Affordability, January 2013

established by health plans to ensure that patients have affordable access to a wide choice of high quality health care providers, and that consumers receive savings when they visit contracted providers who have agreed to lower rates.

Similar concerns are raised by data[13] on hospital prices recently released by the Centers for Medicare & Medicaid Services (CMS). These data show significant variation across the nation and within communities in the amount hospitals charge for common inpatient services. For example, among all hospitals nationwide, CMS reported that the average hospital inpatient charges for services provided in connection with a joint replacement range from a low of $5,300 to a high of $223,000. Additionally, the CMS data show that average hospital inpatient charges for services provided in connection with treating heart failure range from a low of $21,000 to a high of $46,000 in Denver, Colorado and from a low of $9,000 to a high of $51,000 in Jackson, Mississippi.

Provider consolidation is a significant factor contributing to growth in underlying medical costs. A recent study[14] from the Robert Wood Johnson Foundation reports that hospital consolidation generally results in higher prices, stating: "When hospitals merge in already concentrated markets, the price increase can be dramatic, often exceeding 20 percent." The study further cautions that "physician-hospital consolidation has not led to either improved quality or reduced costs" and, additionally, points out that consolidation "is often motivated by a desire to enhance bargaining power by reducing competition."

[13] CMS Press Release, Administration Offers Consumers An Unprecedented Look At Hospital Charges, May 8, 2013
[14] Robert Wood Johnson Foundation, The impact of hospital consolidation – Update, June 2012

In an effort to help inform the public about the impact of rising medical costs, AHIP has developed a new iPad app[15] that consolidates fifty years of federal health care spending data into a series of easy-to-use, interactive charts. Users of this app can view historical and projected health care spending data at the national level, state-by-state, on a per capita basis, or as a percent of GDP. The app also provides a detailed breakdown of how much the nation is spending on different aspects of the health care system, such as hospital care, physician services, prescription drugs, and health plan administrative costs, and how each of these components contributes to health care cost growth.

III. Bringing Down Health Care Costs

Our members are very pro-active in advocating solutions to rein in the costs of health care. AHIP's Board of Directors recently approved a statement recommending a series of strategies to bring down costs and make health care coverage more affordable. These strategies complement the innovative delivery system and payment reform initiatives health plans are spearheading all across the country.

Our Board has recommended three strategies for reducing health care costs:

1. **Tackling Barriers to Transparency:** We call for the elimination of barriers that prevent stakeholders from understanding how markets are (or are not) working. Increased transparency – with a concurrent focus on quality – will give consumers and purchasers a

[15] http://ahip.org/Issues/US-HC-Spending101-App.aspx

clearer perspective on the drivers that are contributing to higher health care costs in their community, as well as an understanding of how dynamics such as provider consolidation affect the costs they pay.

2. **Facilitating Benefit Modernization:** Recognizing that a range of legal, regulatory, or operational barriers often prevent health plan innovations from being adopted in local communities, we believe that cost containment strategies must modernize these "rules of the road" to ensure that innovative plan designs – aimed at decreasing costs while ensuring safe, high quality care – can thrive. This includes re-evaluating scope of practice requirements, accelerating the use of health information technology, promoting preventive care and wellness programs, promoting laws or regulations that support innovative delivery structures, and eliminating excessive network requirements that prevent plans from forming lower cost, high quality networks.

3. **Advancing Bold, Structural Reforms:** Strategies to address rising health care costs need to include fundamental, structural changes in the health care system. Further, action needs to be grounded where health care is delivered today – at the state and local levels. A state-federal shared savings, or "gain-sharing," initiative could be implemented that would allow states to keep a portion of any health care cost savings they generate. This would direct hundreds of billions in needed incentives to cash-strapped states, while at the same time bending the total cost curve and having a productive impact on the economy as a whole, as well as family, corporate, and government budgets.

Building upon the strategies in our Board statement, we have proposed a policy agenda, recently published[16] by the *American Journal of Managed Care* (AJMC), outlining policies that would support and encourage delivery system reform. This agenda includes proposals in the following areas: providing greater transparency on what providers are charging for services; aligning public and private quality measures; promoting administrative simplification and meaningful data exchange; investing in research on what works; promoting scope of practice laws to allow doctors and other clinicians to practice to the "top of their license"; and encouraging states to play a greater role in expanding private-public efforts to bring costs under control.

On another front, AHIP recently joined a diverse stakeholder group, the Partnership for Sustainable Health Care, in releasing a report[17] that outlines recommendations for decelerating health care costs and improving quality. This partnership includes organizations that play a prominent role in the hospital, physician, business, and consumer sectors. We were supported in our work by a grant from the Robert Wood Johnson Foundation.

Our report proposes a set of integrated, system-wide approaches involving both the public and private sectors that will significantly curb the growth in health care spending and enhance the delivery of care. Specifically, we outline a seven-part vision for a transformed health care system: (1) health care that is affordable and financially sustainable for consumers, purchasers, and taxpayers; (2) patients who are informed, empowered, and engaged in their care; (3) patient care that is evidence-based and safe; (4) a delivery system that is accountable for health outcomes and resource use; (5) an environment that fosters a culture of continuous improvement and learning; (6) innovations that are evaluated for effectiveness before being widely and rapidly

[16] AJMC.com, Health Plan Innovations in Delivery System Reforms, April 16, 2013
[17] Partnership for Sustainable Health Care, Strengthening Affordability and Quality in America's Health Care System, April 2013

adopted; and (7) reliable information that can be used to monitor quality, cost, and population health.

The Partnership for Sustainable Health Care report includes recommendations in five key areas:

- **Transforming the current payment paradigm.** We encourage the accelerated adoption of payment approaches that demonstrate their effectiveness in improving both quality and cost. These value-based payment approaches include a range of models that include incentives for patient safety, bundled payments, accountable care organizations, and global payments.

- **Paying for care that is proven to work.** We recommend that public programs and the private sector reduce payments for services that prove to be less effective or of lesser value than alternative therapies.

- **Incentives for greater consumer engagement in care.** We encourage the use of high-value services and providers through tiered cost-sharing and related financial incentives. The goal of such tiered cost-sharing is to create financial incentives for consumers to make better use of their discretionary care choices, leading to savings from improved adherence to preventive measures and evidence-based care, lower utilization of unnecessary services, and the use of more efficient, higher-quality providers.

- **Improving health care infrastructure.** We call for reforms aimed at strengthening the foundational infrastructure of America's health care system so that cost- and quality-related innovations can be implemented more effectively. Specific initiatives include:

- Accelerating research on treatment effectiveness to give patients and providers more information on which to base health care decisions;
- Speeding the adoption and the use of electronic health records and health information exchanges to improve care for patients;
- Ensuring that there is an adequate and diverse health care workforce;
- Reducing and resolving medical malpractice disputes;
- Promoting greater transparency in health care costs; and
- Encouraging competitive markets.

- **Incentives for states to partner with public and private stakeholders to transform the health care system.** We propose a gain-sharing system that would enable states to receive fiscal rewards for successfully meeting cost- and quality-related goals. States would have flexibility to use different combinations of strategies that fit their specific cultures and political environments, ranging from working with private and public payers to collaboratively implement major payment reforms, to modifying scope of practice restrictions, to providing incentives for improvements in care coordination to promote quality and patient safety.

IV. Conclusion

Thank you again for considering our perspectives on these important issues. Our members remain strongly committed to working with Congress, the Administration, and other stakeholders to expand access to high quality, affordable coverage options.