

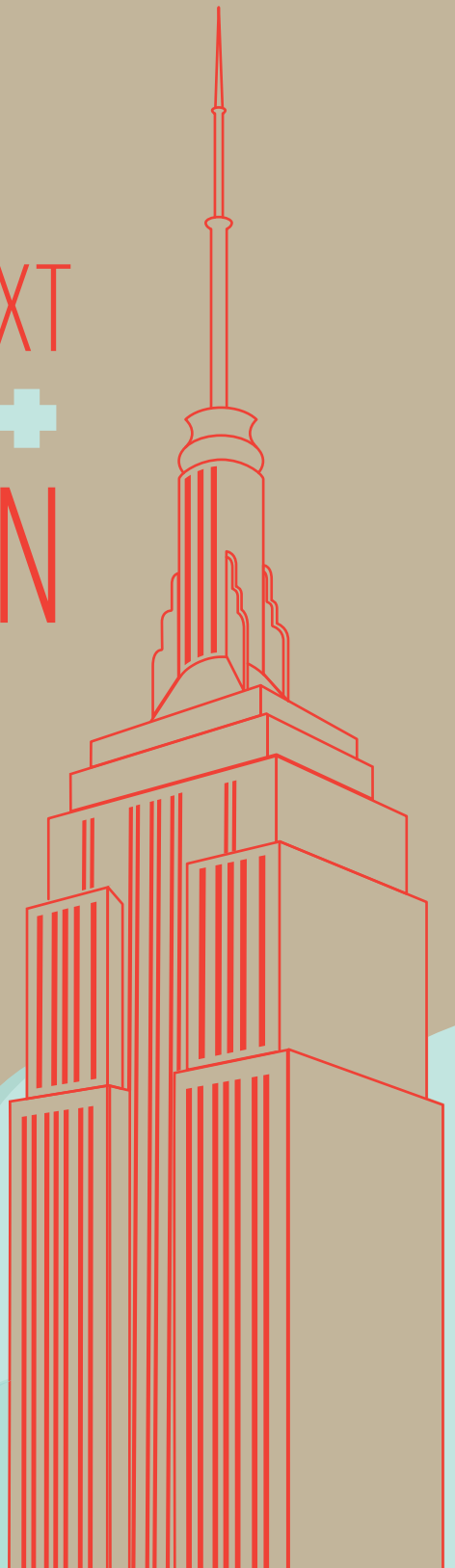
NEW YORK'S NEXT + HEALTH CARE + REVOLUTION

HOW EMPLOYERS CAN EMPOWER
PATIENTS AND CONSUMERS

EDITED BY

PAUL HOWARD +
DAVID GOLDHILL

FOREWORD BY DENIS CORTESE & ROBERT SMOLDT



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Acknowledgments

Support for this work was provided by the New York State Health Foundation. The mission of NYSHHealth is to expand health insurance coverage, increase access to high-quality health care services, and improve public and community health. The views presented are those of the authors and not necessarily those of NYSHHealth or its directors, officers, or staff.

The editors also thank the Manhattan Institute’s Yevgeniy Feyman, who provided invaluable research support and helped coordinate this project among its many authors and drafts.



Contributors



Joseph Antos, the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute, is also an adjunct associate professor of emergency medicine at George Washington University. Antos recently completed seven years as a member of the Panel of Health Advisers for the Congressional Budget Office. In addition, he recently completed two terms as a commissioner of the Maryland Health Services Cost Review Commission.

Prior to joining AEI, Antos was assistant director for Health and Human Resources at the CBO. He has held senior management positions in the U.S. Department of Health and Human Services and the Office of Management and Budget, and he was a member of the President's Council of Economic Advisers. Antos has extensive experience as an advisor to the U.S. Agency for International Development, the World Bank, and governments in Europe and Asia. He has written, lectured, and testified before Congress on the economics of health policy, including Medicare and broader health system reform, health care financing, health insurance regulation, and the uninsured. He holds an MA and a PhD in economics from the University of Rochester and a BA in mathematics from Cornell University.



Leah Binder is president and CEO of the Leapfrog Group, a D.C.-based national nonprofit that represents employers and other purchasers of health care. Leapfrog urges improved safety and quality in American hospitals. Binder is a regular contributor to Forbes.com, the Huffington Post, and the *Wall Street Journal*. In 2014, she was named by *Modern Healthcare* as one of the top 100 persons in U.S. health care.

Prior to her current position, Binder spent eight years as vice president at Franklin Community Health Network, an award-win-

ning rural hospital network in Farmington, Maine. She previously was a senior policy advisor for the office of Mayor Rudolph Giuliani. Binder began her career at the National League for Nursing, where she handled policy and communications for over six years. She holds a BA from Brandeis University and two MAs from the University of Pennsylvania: from the Annenberg School of Communication and from the Fels Institute of Government.



David Goldhill is president and CEO of the Game Show Network, which operates a U.S. cable television network seen in more than 80 million homes, as well as one of the world's largest digital games companies. He is the author of *Catastrophic Care: Why Everything We Think We Know About Health Care Is Wrong*, an original investigation of health

care in America—why it is failing and how it can be transformed.

Goldhill, who speaks regularly on health care topics, recently spoke at events sponsored by Harvard Medical School, Duke University, Vanderbilt University, Institute of Medicine, Manhattan Institute, RAND Corporation, World Health Care Congress, and Association of Healthcare Journalists. He has written op-eds for the *New York Times*, *Wall Street Journal*, *Washington Post*, *Time*, and Bloomberg View and has appeared extensively on television and radio, including on NPR, CNN, Fox News, and MSNBC. Goldhill, a member of the board of directors of the Leapfrog Group, holds a BA in history from Harvard University and an MA in history from New York University.



Paul Howard is a Manhattan Institute senior fellow and director of the Institute's Center for Medical Progress. He is also a contributor to The Apothecary, the influential Forbes blog on health care policy and entitlement reform, and a regular columnist for The Morning Consult.

Howard has written on a wide variety of medical policy issues, including FDA reform, biopharmaceutical

innovation, consumer-driven health care, Medicare and Medicaid policy, and health care reform. He is often quoted on health care issues, and his columns and essays have appeared in national publications, including *Bloomberg View*, *Wall Street Journal*, *National Affairs*, *USA Today*, *RealClearPolitics*, *New York Post*, *Investor's Business Daily*, *Health Affairs*, and *FoxNews.com*. He holds a PhD in political science from Fordham University and a BA from the College of the Holy Cross.

Robert Emmet Moffit, a senior fellow at the Center for Health Policy Studies at the Heritage Foundation, was recently appointed to the Maryland Health Care Commission by Governor Larry Hogan. Moffit served in President Reagan's administration, where he was appointed deputy assistant secretary for legislation at the U.S. Department of Health and Human Services. Before his service at HHS, Moffit was an assistant director of the U.S. Office of Personnel Management. He joined the Heritage Foundation in 1991, and became director of domestic policy. In 2010, Moffit was named by *Modern Healthcare* as one of the top 100 persons in American health care.



Moffit has received public service awards from the American College of Eye Surgery, Great Lakes Association of Clinical Medicine, and National Hispanic Families Against Drug Abuse. He is president of the Buckley School Foundation, which promotes critical thinking, debate, and public speaking skills. Moffit has appeared on ABC News, NBC News, CBS News, CNN, CNBC, Fox News, and PBS *NewsHour*. His articles have appeared in the *Harvard Health Policy Review*, *Health Affairs*, *Journal of Medicine and Philosophy*, *National Affairs*, *The Hill*, *National Review*, *National Interest*, *Irish Independent*, *Wall Street Journal*, and *Journal of Law, Medicine & Ethics*. Moffit holds a BA in political science from La Salle University, as well as an MA and a PhD, both in political science, from the University of Arizona.



Laurel Pickering is president and CEO of the Northeast Business Group on Health—a 200-member business coalition representing more than a million insured individuals—which is committed to market-based health care reform, quality improvement, and value-based purchasing. NEBGH provides employer perspective on health care

issues to legislators and health care–related organizations. At NEBGH, Pickering has focused on mobilizing the business community to drive improvements in health care; providing access to health insurance for small businesses by creating a health insurance exchange; and organizing health plans to work together to improve quality and value. She is chair of the board of directors of the NEBGH subsidiary HealthPass, a health insurance exchange for small businesses. NEBGH leads the Leapfrog Group’s regional rollout in the New York metro area, an initiative that Pickering is overseeing.

Pickering serves on the board of directors of the National Quality Forum, Leapfrog Group, Health Republic, National Business Coalition on Health, and Foundation for Art & Healing, as well as on the advisory council of the commissioner of NYC’s Department of Health and Mental Hygiene. She was selected as one of New York’s rising stars by *Crain’s* and featured in its 2007 “40 Under 40” issue. Pickering holds a BA in anthropology from SUNY-Albany and an MPH from Emory University.



Mario Schlosser is CEO and cofounder of Oscar, a health insurance start-up that uses technology, design, and data to humanize and simplify health care. He also cofounded Vostu, one of the largest social gaming companies in Latin America, where he led the company’s analytics and game-design practices.

Previously, Schlosser was a senior investment associate at Bridgewater Associates, where he developed analytical trading models. Prior to Bridgewater, he was a consultant at McKinsey & Company in

Europe, the U.S., and Brazil. As a visiting scholar at Stanford University, Schlosser wrote and coauthored ten computer science publications, including an oft-cited paper in which he developed an algorithm to securely compute trust in randomized networks. He holds a degree in computer science from the University of Hannover in Germany and an MBA from Harvard Business School.

Foreword

Denis A. Cortese, MD

Robert K. Smoldt, MBA

A patient facing a serious or life-threatening illness needs an accurate diagnosis and effective treatment. The same is true for the U.S. health care system. America's health care costs per person and as a percentage of its economy are the highest in the world, threatening the long-term solvency of U.S. states and the federal government. Despite such outsize spending, patient outcomes, safety, and access to appropriate care are too often disparate and inconsistent. The good news: for a variety of reasons, many of the system's key players appear ready to make fundamental changes that will move the U.S. to higher-value health care.

Value is a simple, powerful concept that drives innovation and competition across the private sector; if appropriately measured and rewarded, it can revolutionize how we pay for and deliver effective health care, too. Broadly speaking, value represents patient outcomes, safety, and satisfaction “divided” by cost per patient, over time. Such factors can now be measured with increasing accuracy at the level of plans, hospitals, and physicians. For instance, patient outcomes and safety measurements can include such items as risk-adjusted mortality, reductions in unnecessary procedures, declines in hospital-acquired infections, fewer prescription drug errors, and less time required for patients to return to normal activity—including employment—after major surgery.

Patient satisfaction levels can be obtained from national surveys reported by the Centers for Medicaid and Medicare Services. Medical costs are coming under increased scrutiny through transparency tools that allow patients and consumers to see their full out-of-pocket costs for in- and out-of-network services. When calculating value, cost is perhaps the factor most likely to be misdiagnosed. Some observers believe that simply lowering the amount paid for various services (per physician visit, per lab test, per imaging test, per surgery, etc.) will solve America's health care cost problem. Yet decades of experience reveal that low-deductible health insurance and price controls do not reduce total spending. If anything, the opposite is true.

Like value, total health care spending per capita can be stated in a simple, powerful formula: price paid, per service item, multiplied by use rate. Studies by Dartmouth University and others suggest that, in the U.S., the difference between high-cost areas and providers and low-cost areas and providers is mainly the result of differences in usage rates. Such evidence reinforces the conclusion that, despite decades of top-down micromanagement from Washington, the U.S. does not receive sufficient value for its health care spending.

New York's Next Health Care Revolution: How Public and Private Employers Can Empower Patients and Consumers offers a bold new approach by recognizing that reforms need not only happen at the national level; local changes, spurred by government and the private sector, can also lead to significant improvements. The essays herein are equally infused with a justified dose of optimism: reform efforts, thanks to a confluence of factors, including the Affordable Care Act and a growing number of effective, private-sector health care experiments, are beginning to spur the changes necessary to make the delivery of high-value health care the cornerstone of American medicine.

New York State, like the country as a whole, confronts health care challenges and opportunity in equal measure. As Laurel Pickering notes in Chapter 1, patients in the Empire State are largely left in the dark about what they actually receive for their health care dollars. Further, despite vast outlays, including one of America's most expensive Medicaid programs, New York's health care outcomes tend to be middle-of-the-pack. At the same time, New York enjoys a large base of world-class hospitals, a savvy tech infrastructure, and a business community with strong incentives to lower the burden of health care costs.

The essays' underlying goal? Reform New York's convoluted health care arrangements to empower patients to demand more value. For example, making patient outcomes and cost metrics more readily available will help the new cohort of patients with high-deductible plans to navigate an opaque system. Value-based benefit designs can encourage patients to focus on care that improves outcomes and controls costs. Rethinking the state's role in competition—from regulating insurance to encouraging nimble new competitors who can re-bundle health care services (via telemedicine and direct contracting, for example)—can lower costs and launch virtuous cycles of value-focused innovation.

The essays' focus on the "patient-consumer's" role in value-based competition is what makes this short book so valuable. It lays out a road map for public and private employers to create a level playing field, wherein insurers and providers compete to deliver high-value health care.

Henceforth, meaningful health care reform will require individuals to accept significantly more responsibility for their own health care, both financially and as decision makers. Yet the growing tide in favor of health care consumerism presents transformational opportunities and challenges that can be navigated only with the help of providers, provider organizations, employers, and policymakers.

The key to bringing more value to patients is to introduce incentives that reward the provision of high-value care. Patient-centered reforms—including greater transparency, private exchanges, and value-based payment and benefit designs—will likely unleash a wave of positive change that grows in force over time. Of the many needed reforms proposed in the following chapters, value-based payments are arguably the most urgent and important. As Joseph Antos explains in Chapter 2: "Payment reform can discourage the fragmentation and overutilization that has defined fee-for-service contracts to date, while encouraging innovation and competition in the delivery of care."

Indeed, when we pay for value, we're more likely to get it. By channeling competition at the level of the patient-consumer, we can ensure that the providers who deliver the best value to patients will be rewarded, creating demand for yet more innovation. *New York's Next Health Care Revolution* articulates a clear, succinct vision—and the steps required to get there. New York's employers and policymakers should take note. In doing so, they will set a salutary example for the rest of the nation on how to begin curing the ills that afflict American health care.

Denis A. Cortese is Foundation Professor and Director of the Healthcare Delivery and Policy Program at Arizona State University and Emeritus President and CEO of the Mayo Clinic.

Robert K. Smoldt is Associate Director of the Healthcare Delivery and Policy Program at Arizona State University and Emeritus Chief Administrative Officer of the Mayo Clinic.

Empowering the Patient-Consumer: New York's Challenge and Opportunity

David Goldhill, *Game Show Network*

Paul Howard, *Manhattan Institute*

Overview

Health care policy debates often center on the role of the federal government, but New York and the other states also have important roles to play under the Affordable Care Act (ACA). In many of the areas discussed in the subsequent chapters of this volume—transparency, competition, regulation, licensing, safety—state policy can assume a primary role in driving innovation.

New York has considerable advantages: leading hospitals, medical schools, and research centers; world-class physicians; extensive public-health facilities; and major health care foundations. Wall Street can finance innovative health care firms. The state is home to some of America's leading employers, who have experimented for decades with tools to “bend the curve” of health care spending. And New York's government employs some 250,000 people,¹ affording it huge leverage to mold provider practices.

Despite such strengths, New York's health care system, like that of other states, does not provide the information on safety and quality necessary for consumer-driven health care to succeed. Failure to reform will hurt patients (particularly the poorest and sickest), taxpayers, and New York's economy. In *New York's Next Health Care Revolution: How Public and Private Employers Can Empower Patients and Consumers*, five distinguished experts from academia, business, and the not-for-profit

world identify New York's major hurdles to reform—and propose solutions to overcome them.

In **Chapter 1**, Laurel Pickering, president and CEO of the Northeast Business Group on Health, highlights the most distinctive features of New York's current health care market. In **Chapter 2**, Joseph Antos, Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute, examines how limited competition between providers produces mediocre health outcomes in the Empire State. In **Chapter 3**, Leah Binder, president and CEO of the Leapfrog Group, details the frightening scarcity of publicly available information on provider safety. In **Chapter 4**, Mario Schlosser, cofounder and CEO of Oscar Health Insurance, explains how technology can transform New York's health care outcomes. And in **Chapter 5**, Robert Moffit, senior fellow at the Heritage Foundation's Center for Health Policy Studies, discusses the untapped potential of private health-insurance exchanges. Their recommendations for reform share fundamental objectives:

- Simplify health care for patients by making it easier to make better choices.
- Connect patients with the information they need, when they need it.
- Encourage innovative health care business models that deliver better value.
- Liberate the data that allow patients, employers, providers, and plans to identify the safest, most effective providers and treatments.
- Use competition as a platform to drive disruptive innovations in health care reimbursement and delivery systems—to boost economic growth and ensure that New York's economy and health care system thrive in the twenty-first century.

Patients' engagement (i.e., appetite for consumerism) will, of course, vary by health status and socioeconomic factors. Our suggested reforms will not, in other words, apply equally to all patients at all times. For the Medicaid population, particularly those with serious mental illnesses or developmental challenges, and the disabled elderly,

policymakers will likely need to consider a different set of interventions to maximize outcomes and produce better value.

Yet embracing transparency and competition across the health care system—thereby engaging the median “patient-consumer,” as well as the vast majority of employed New Yorkers—will produce spillover benefits for populations with chronic diseases. Better data on health outcomes will help patients identify the best providers for their needs, especially as value-based benefit designs, tiered networks, and reimbursement contracts that reward high value providers become more common. In fact, patients suffering chronic diseases have the most to benefit from a truly patient-focused, value-driven health care system.

Background

Speaking at a New York State Health Foundation conference in 2013, health economist Uwe Reinhardt called the U.S. health care system a “fortress,” with prices determined in secret negotiations by a small group of “nobles.”² For most American patients with health insurance—including the roughly 150 million Americans with employer-sponsored coverage³—the only price they typically see is the co-pay (often as low as \$20 for a simple doctor’s visit that costs \$100). With third-party payers (insurance companies, government, and self-insured employers) paying the rest, the true price of health care is hidden from patients.

Fortress U.S.A. developed in response to the widespread “first-dollar” traditional health insurance coverage offered by employers.⁴ Yet for the first time in years, Fortress U.S.A. is under siege as consumer-directed health plans with high deductibles spread rapidly. While the merits of these plans have long been debated, their increasing prevalence is a fact. At the start of 2014, some 580,000 nonelderly New Yorkers were covered by health insurance plans with deductibles of at least \$1,250 a year for individuals, making these plans eligible for health savings accounts (HSAs).⁵ Many of the roughly half a million New Yorkers enrolled in policies offered on the New York State of Health exchange have high-deductible plans, too: the average deductible for Bronze plans, the most affordable plans on the state’s public exchange, is \$3,000 for individuals and \$6,350 for families.⁶

The primary goal of the ACA was to expand coverage to the uninsured; but a side effect seems to be the marked acceleration of growth in high-deductible health plans and narrow networks in the private market.⁷ Patients are now more keenly interested in the price, safety, and quality of the health care products and services that they buy—just as they are when they shop for other big-ticket items such as homes, computers, and automobiles. For the first time, millions of Americans, including hundreds of thousands of New Yorkers, are becoming true patient-consumers.

Empowered with meaningful information, patient-consumers can begin to make real choices among competing insurers and provider networks. This presents a massive opportunity to transform America's uncompetitive, opaque health care system, ruled by powerful incumbents, into a competitive market, where delivering better care at more affordable prices matters.

The spread of high-deductible health plans (HDHPs) is not the only reason the role of patient-consumers will increase. Other insurance designs will require patient-consumers to make conscious trade-offs on the size and scope of their provider network (generally, the tighter the network, the lower the deductible), drug formulary design (more branded drugs versus cheaper generics), and willingness to embrace chronic-disease screening and management programs. Few plans on New York's health insurance exchange, for instance, cover Memorial Sloan Kettering Cancer Center, one of America's leading cancer treatment institutions. Further, almost all plans on New York's health insurance exchanges do not offer *any* coverage for services performed by out-of-network physicians and hospitals. When choosing an insurance plan, families therefore need to find not only an affordable premium but an acceptable deductible and an adequate provider network for their specific health needs.

Innovative payers and employers, from Intel to CalPERS, are experimenting with creative reimbursement approaches, including reference-pricing and direct contracting, that will further limit consumers' exposure to high deductibles and other cost-sharing—as long as patient-consumers are willing to seek care at providers that accept the reference price. Going outside the network will be possible but will include added costs. Such features will be reflected in the prices facing patient-consumers.

While HDHPs will not be the only option on offer, their uptake will be the major catalyst reshaping the economic relationship between plans, providers, and patients. HDHPs are likely to have the greatest impact on the direct relationship between patients and providers: the experience of paying 100 percent of bills under the deductible will affect patients' expectations. The question of value—of price in relationship to the quality of services rendered—will become increasingly paramount.

Transparency tools will arise out of necessity; no employer wants to leave employees stumbling in the middle of a serious illness. But Fortress U.S.A. poses a major barrier to change. Without price transparency, reliable quality measurements, and genuine provider competition, American patient-consumers will find their new financial responsibilities a greater burden and, at worst, a real impediment to obtaining appropriate care.

Still, no fortress is impregnable. As a critical mass of insured patients becomes patient-consumers, we should expect providers to respond to their needs with different models of service. But relying solely on organic change may be too slow and limited at a time of rapid shifts in health care purchasing responsibility. Concerted action—by employers, providers, union health plans, and government—may be necessary to ensure that patient-consumers are protected during what is likely to be a protracted transition and that the promise of a more consumer-directed health care system is realized.

This is a watershed moment: if New York stands on the sidelines, patients will suffer and little will change. New York has the opportunity and responsibility to take advantage of the aforementioned trends. Through a variety of policies discussed in the following chapters, the Empire State can “right-size” its health care spending, thereby turning its health care system into a true patient-centered market. If New York policymakers, payers, and employers step up to the plate, a much needed revolution in U.S. health care will occur.

I. Employers' Continued Relevance Under the ACA

The New York State of Health exchange has revitalized the state's market for private, nongroup insurance. In 2010, 26,000 New Yorkers directly purchased private coverage;⁸ today, roughly 400,000 New Yorkers do.⁹

Nevertheless, New York's employers will continue to be the most important source of private health insurance coverage (through employer-sponsored insurance, or ESI). As such, they will play a leading role in the evolution of the state's health care system. The Congressional Budget Office—Congress's nonpartisan fiscal scorekeeper—does not expect widespread employer “dumping” of workers onto the ACA exchanges even though many employers face financial incentives to do so. In early 2015, the agency estimated that by 2024, 161 million nonelderly people (about 57 percent of the nonelderly population) will still be covered by employer plans.¹⁰ There is no reason to expect these trends to diverge in New York.

ESI's likely continued dominance largely stems from the fact that employers still view health insurance coverage as a competitive advantage in labor markets (due to ESI's favorable tax treatment);¹¹ that employees still trust employers to provide coverage responsibly; and that the ACA presumes a continued major role for employers through its employer mandate.

Over the past decade, HDHPs have become increasingly common in the employer-sponsored health insurance market. A 2014 survey by Towers Watson and the National Business Group on Health found that nearly 75 percent of large employers offered an “account-based health plan”—a high-deductible plan with an associated savings account—with 30 percent expecting to offer only an account-based plan in 2015. Additionally, more than one-third of employers view “consumer-driven health plans” as the most effective tactic to control health care costs.¹²

Reinforcing and accelerating this shift in the employer-sponsored market is the ACA's “Cadillac tax,” which imposes a 40 percent excise tax on commercial health plans valued above \$10,200 for individuals, and \$27,500 for families. Scheduled to take effect in 2018, the Cadillac tax is especially significant because the threshold plan value for the tax is indexed to overall consumer inflation (which tends to grow more slowly than health care inflation), rather than medical inflation. This means that, over time, many more plans and employers will be exposed to the tax. Analysts from the Johns Hopkins School of Public Health estimate that in 2018, 16 percent of plans in the employer market will incur the tax; by 2028, this figure will rise to 75 percent.¹³

Employers are, naturally, reacting to this large, looming tax. Mercer reports that 66 percent of large employers (500+ employees) and 88 percent of “jumbo” employers (20,000+) expect to offer a consumer-driven health plan by 2017.¹⁴ (For all employers with more than ten employees, the rate is lower, Mercer found, but still an impressive 36 percent.)

Though the ACA exchanges are less than two years old, we can anticipate increasing convergence between employer-sponsored insurance and the individual market, with both moving toward a consumer-directed model. Indeed, on the ACA exchanges, about one-quarter of offerings are already HSA-eligible.¹⁵ It may be too early to project exactly how these plans will affect consumer and provider behavior. But as covered employees and the newly insured on the exchanges begin to understand how their high-deductible and narrow-network plans work, the tremendous opportunities and challenges of HDHPs are coming into focus.

II. Consumer-Directed Health Care: The Opportunity

The growing prevalence of high-deductible plans offers two important potential benefits. First, there is evidence that HDHPs can control the rate of insurance premium growth without significantly affecting health outcomes.¹⁶ Second, increasing patient-consumers’ purchasing power will force providers to compete on price and quality, leading to increased transparency and value across the health care system. As the individual and employer-provided insurance markets begin to look more alike (i.e., more consumer- and value-focused), large public and private employers have an opportunity to leverage the combined purchasing power of both markets in ways that will finally tilt the health care playing field in favor of patient-consumers.

Even under the highest-deductible plans, most of the costs of catastrophic illnesses will still be fully covered by insurers. However, critics of HDHPs worry that financially strapped families may put off lower levels of needed care. The ACA partly addresses this by mandating that certain preventive care be deductible-free. But patients requiring ongoing, non-catastrophic treatment (such as long-term prescription drugs) may be at risk. The ACA did little to encourage the spread of HSAs, which can help ensure that patients with HDHPs do not postpone or neglect needed care.

For families facing “only” routine expenses, high-deductible plans likely will mean that almost all their annual spending on care (excluding certain preventive services, as defined in the ACA)—a median of about \$780 annually¹⁷ and up to the ACA’s out-of-pocket maximum of \$13,000 per family—will be paid 100 percent out-of-pocket. This will represent a powerful incentive for changing patient-consumers’ mindsets. The spread of HDHPs also promises growing opportunities for forward-thinking providers, innovative technology companies, and entirely new health care business models. Over the next few years, Fortress U.S.A. will be under siege by millions of middle-class families accustomed to the far better customer service, competition, and transparency that they experience in other areas of their lives.

III. Transitioning to Consumer-Directed Care

The ACA exchanges were founded on the idea that individuals can select the best coverage from a range of transparent, comparable offerings from competing insurers. In practice, Americans face a uniquely unfriendly consumer experience when considering the direct purchase of health care.

As Joseph Antos notes in Chapter 2, information routinely available to consumers in other markets—clear prices, bundled services, and expert reviews of competing options—is almost nonexistent in health care. Billing statements are often incomprehensible, with providers reserving the right to bill undisclosed amounts for additional services at a later date. Smoothing the transition for patient-consumers will mean addressing these uncertainties.

Likewise, the long-run success of HDHPs in the employer and individual markets depends on the availability and clarity of information on health care goods and services. Isolated pockets of information do exist: Healthcare Effectiveness Data and Information Set (HEDIS) offers some indication of network quality; Medicare Hospital Compare gives some idea of individual facility quality; and pricing for MRIs and other discrete services can sometimes be secured through consumer-facing firms. But such pieces of information rarely help patient-consumers clarify the entire health care market puzzle. If the ACA is to succeed—and if employers are to maintain their role in offering

insurance coverage—it will mean reshaping health care information in ways that make HDHPs (and other tools designed to make patient-consumers better shoppers, such as narrow networks and value-based insurance) empowering for individuals and families.

In market economies, competition drives change. At present, where competition exists among U.S. health care providers, it is restricted to efforts to win the business of insurers. For patient-consumers, on the other hand, prices are not posted and outcomes not reported. Nor does the trend toward hospital consolidation—which often results in higher prices¹⁸—look likely to boost competition for patient-consumers.

New York's highly regulated health care market, dominated by large payers and providers, has seen little of the business model innovation that has transformed most other American industries. The state's health care consumer-protection laws focus too much on insurance issues and limitations on competition, rather than on regulations to help consumers make better choices. Perversely, the practical effect of New York health care regulation has largely been to reinforce Fortress U.S.A., shielding large, plodding incumbents from small, nimble entrants. Ostensibly designed to constrain hospitals' ability to artificially manufacture demand for their services, the state's "certificate-of-need" laws are a particularly glaring example of regulation harming patient-consumers.¹⁹

New York's providers must face new incentives to experiment with and diversify their prices, thereby imitating the discounting, repackaging, and range of service models widespread elsewhere in the U.S. economy. Competition at the patient-consumer level will encourage providers to better justify needed services, simplify paperwork, and integrate care with other providers when this delivers better, less costly care. Telemedicine and remote monitoring, facilitated by wearable diagnostics, can enable faster surgery rehabilitation without exposing patients to hospital-acquired infections. Better-integrated technology and, where appropriate, shifting to community-based care, would benefit all patients, including those with high-deductible plans.

Hate them or love them, HDHPs are here to stay. Employers and policymakers should therefore leverage their continued growth to transform Fortress U.S.A. Though HDHPs have helped slow the rise in health care costs,²⁰ their full potential will be stymied, too, until a critical mass of payers forces providers to transform their practices. Indeed, until

a consumer-friendly health care landscape emerges, HDHPs will threaten New Yorkers' wallets—and, perhaps, their health.

What Private Employers Can Do

As they increasingly shift workers to HDHPs, employers need to encourage employees to accumulate health savings; they should also encourage the development of consumer tools that help employees make smarter health choices—through the use of reference pricing, private health insurance exchanges with defined-contribution options, or direct contracting with providers. Specifically, private employers should:

1. Ensure that employees with HDHPs have associated HSAs, as well as a default option encouraging savings accumulation. Many employers encourage utilization of HSAs by shifting shared savings from lower premiums into the HSA, making HDHPs more attractive and reducing the risk that employees will defer needed care.
2. Utilize cost and transparency tools that make it possible for employees to shop effectively, in and out of network, for health care services. Studies suggest that employees with HDHPs and pricing tools tend to seek out lower-cost providers—such as for diagnostic services—without sacrificing quality.
3. Urge insurers to release risk-adjusted outcomes data from providers; utilize reference pricing; and develop other performance-based reimbursement contracts, thereby transitioning away from fee-for-service reimbursement. Begin with high-cost patients and gradually expand into lower-cost tiers.
4. Embrace proven disease-management tools for employees, avoiding expensive, painful complications from ailments such as diabetes and heart disease.

What Public Employers Can Do as Payers

New York's two largest employers are its state government and New York City, with, respectively, 250,000 and 300,000 employees.²¹ They, unlike fragmented private employers, have the size and leverage in New

York's market to use their coverage policies to demand change in underlying provider practices. Given public employees' long tenures and generous post-employment health and pension benefits, public employers also have an even greater incentive than their private counterparts to offer prevention- and disease-management programs to ensure that their employees stay healthy.

While public-employee unions may be reluctant to embrace HDHPs, reductions in cost growth for public plans can be shared with public employees in the form of higher wages. As private-insurance markets and new purchasing models offer opportunities for cost savings, public contract negotiations should focus on value-based purchasing, shared savings, and transparency reforms to support patient-consumers across public and private markets.

Because public employers are subject to the Cadillac tax in 2018, unreconstructed health care arrangements for public employees will negatively affect state and city finances. Therefore, changes in insurance and provider contracts can provide a useful starting point for an enduring partnership with public-sector unions to build cost savings into contract arrangements. Albany and its municipalities should:

1. Use their negotiating leverage to drive reimbursement and transparency reforms. Draw on innovative private- and public-sector practices adopted in California, Massachusetts, and elsewhere—such as reference pricing, tiered-benefit plans, direct contracting, and value-based insurance.
2. Offer HDHPs and HSAs, where possible, to union members, including through a “hold harmless” design (where employers fully fund the HSA, making it directly comparable with many New York plans with first-dollar coverage).
3. Make hospital safety disclosures mandatory, especially through contract provisions that offer premium discounts to state and municipal employees who choose networks with safer hospital systems.
4. Consider a private exchange model for New York State workers, modeled after the Federal Employees Health Benefit (FEHB) program. A defined-contribution model in a private exchange

would allow employees to seek out the lowest-cost, highest-quality plans and deposit ensuing savings into HSA accounts.

What Albany Can Do as Policymaker

Government policy must shift focus, from managing the relationship between insurers and beneficiaries, to enhancing patient-consumers' interactions with providers. Existing approaches to health care regulation should be reexamined to encourage competition and adoption of new, transformative business models. In the new health care market, as in other markets, choice, diversity, and disruptive innovation are to be prized. New York's policymakers should:

1. Examine all licensing statutes to ensure that health care providers are allowed to provide all the services for which they are trained (i.e., practice at the top of their license).
2. Require Medicaid and other public programs to reimburse providers equally, based on services provided, not the location of services provided.
3. End the current prohibition on the corporate practice of medicine for providers who comply with reporting requirements to New York's (evolving) cost and quality databases (such as the SHIN-NY and all-payer claims databases).
4. Be agnostic about what type of provider (e.g., for- or not-for-profit) should perform various services—so long as service quality and pricing are transparent.
5. Repeal regulations discouraging competition among providers and encourage new business models that deliver high-quality care at affordable prices.
6. Expand nascent telemedicine initiatives and allow consumers and insurers to seek care and advice from licensed providers in other states. This could be achieved through reciprocity agreements with other states.
7. Commit the state's exchange to include far more pricing and quality information that can help consumers seek out the best insurers and provider networks.

8. Grow and unleash the state's nascent health care databases. Open them to commercial researchers who can translate data into actionable information for specific (i.e., not average) consumers, through smartphone and web apps offering customized searches, such as "What's the best hospital for a 50-year-old female diabetic with heart disease?"

What Providers Can Do

New York's highest-quality, lowest-cost providers will thrive in a transparent, competitive market. Under such conditions, however, all providers must adjust their practices to accommodate millions of new patient-consumers, increasing transparency, enhancing navigability, and assisting patient choice. Providers should:

1. Post safety data, outcome measures, and prices on clear, easily accessible websites.
2. Make clear what patients will be billed for at the time of service—with no exceptions.
3. Reject so-called anti-steering and anti-transparency insurance contract provisions that do not permit insurers or employers to communicate pricing and quality data to consumers.

These reforms would accelerate the Empire State's nascent health care revolution by, for the first time, making patient-consumers the most valued members of New York's health care system.

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New York at the Crossroads: Big Challenges, Bigger Opportunities

Laurel Pickering, *Northeast Business Group on Health*

Introduction

Suddenly, New York is having a moment. A perfect storm of factors—including the Affordable Care Act (ACA) and state initiatives on cost containment, payment reform, data sharing, and quality of care that are taking effect or being seriously considered—could give the state the opening it needs to pull off the seemingly impossible: remake its health care system by using market forces and transparency to help consumers and patients navigate their way to better care, lower costs, and less frustration.

Thanks to dozens of teaching hospitals, medical schools, research facilities, and a commitment to cutting-edge medicine, New York has long had a high profile in health care. With marquee names such as the Hospital for Special Surgery, Memorial Sloan Kettering, New York–Presbyterian, and NYU Langone Medical Center, the state has been a leader in training the nation’s doctors and draws countless patients annually from across the U.S. and around the world.

New York has also been a laggard. When it comes to soaring prices, uneven outcomes, consumer confusion, and other symptoms of America’s flawed health care system, the state is often found in the middle of the pack—and sometimes near the bottom. New York spends more on health care, per household and overall, than most other states. By 2020, such spending will likely exceed \$300 billion, according to the Lewin Group.¹ New York’s Medicaid spending is also among the nation’s highest: first in total expenditures, second in per-capita outlays, and third in per-enrollee expense.²

Despite such outsize spending, the state ranks near the middle nationally on avoidable hospitalizations;³ is seventh-highest in average length of stay in community hospitals;⁴ spends the fifth-highest amount on Medicare beneficiaries in the last two years of life; and ranks no better than 21st for healthy life expectancy at age 65.⁵ All this makes the need for change even more urgent. If New York succeeds in “right-sizing” its health care system, thereby extracting more value from it, the Empire State could claim a national leadership role in health care reform and greatly improve its economic competitiveness. But moments have to be seized—and in the byzantine world that is U.S. health care, success is never assured.

I. The Affordable Care Act

Now, as the U.S. health care system continues to reshape itself in response to the ACA, New York (along with the rest of the country) is just starting to factor in the act’s so-called Cadillac tax on employer-sponsored insurance (ESI) and the costly impact it will have on millions of workers who do not yet realize they are going to be affected. Implementation of the tax is still several years away; yet it is already causing many companies to take steps to avoid it by accelerating the shift to high-deductible health plans (HDHPs).⁶ Even when coupled with tax-favored Health Savings Accounts (HSAs), HDHPs can sharply raise out-of-pocket costs for employees and their families.

The Cadillac Tax: More Skin in the Game

While employers will continue to play a critical role in helping employees navigate health insurance options, the reality of the ACA is that consumers are being asked to take more financial responsibility for their routine care.

Still in its early days (HSAs, a cornerstone of consumer-directed insurance, were created in 2003), consumer-directed care⁷ is the by-product of the growing shift in the cost of insurance from employers to workers (a transfer that Obamacare is likely to accelerate). Under current law, employers can deduct the cost of health insurance that they provide to their workers, who pay no tax on the benefit. Traditionally, the employer has borne most of the cost of the insurance, leaving

workers with little out-of-pocket expense. One effect of this arrangement was to insulate employees from the cost of their care, thereby largely shielding the health care system from pressure to contain costs. The Cadillac tax will help begin to unravel such dynamics because employers will save money by shifting more costs to employees.

Starting in 2018, employers will be taxed on their most expensive plans—those costing more than \$10,200 annually in premiums for individuals and \$27,500 for families.⁸ The tax also is indexed to consumer price inflation, meaning that many more plans will be subject to the levy over time. (Most plans currently offered by New York State and New York City to their workers will likely be subject to the Cadillac tax by 2020.)⁹ One way employers are responding to this sea change is by accelerating the shift to HDHPs, which have lower premiums that do not trigger the tax. Because HDHPs have much higher deductibles than typical existing policies, employees will be forced to put more skin in the game, thereby becoming more involved in health care decision making.

While such change may be unwelcome for many employees—at least, initially—tax-shielded HSAs will cushion some of the shock. Employees can also contribute pretax dollars from their paychecks to the accounts to pay for medical expenses; some employers are contributing, too. But, like it or not, the Cadillac tax is coming, adding new force to an ongoing trend, one that will ultimately benefit consumers through better care at better prices. Health care's future is—and must be—consumer- and patient-focused.

II. The Need for Transparency

To survive in this new environment, health care consumers will need to make informed decisions about what coverage to obtain and which providers to use. But consumers in New York and many other states lack sufficient access to the information on prices, safety, quality, and customer service necessary for a truly consumer-driven health care system to work. Indeed, most data on cost, physician, and hospital performance and treatment outcomes are either a challenge to understand or simply unavailable.

Improved transparency on the cost and quality of providers will benefit the hundreds of thousands of New Yorkers shopping for insurance on

the state's health insurance exchange, too. Given the growing prevalence of “narrow networks,”¹⁰ picking a quality insurer depends on consumers' ability to choose between competing networks of providers and hospitals.

But in order for health care consumers—whether employees or shoppers on the state exchange—to become informed and make meaningful choices for themselves and their families, policymakers in Albany and New York City must join the state's business community to enact reforms to facilitate easy pricing and quality comparisons. Ultimately, better information in a more transparent market will enhance competition among providers and insurers, driving a race to provide high-quality care at the lowest cost.

III. What Legislators Can Do

To seize its moment and get as many consumers as possible using cost-effective, high-quality providers, New York must rise to the challenge. Encouragingly, the Cuomo administration has signaled that it is serious about systemic transformation. It is currently pressing forward with a number of initiatives designed to slow the rise in costs and improve quality.

One of the biggest initiatives involves the state's \$50 billion Medicaid program. Thanks to a federal waiver, New York launched its Delivery System Reform Incentive Payment (DSRIP) program in early 2014—a five-year, \$6.4 billion experiment to coordinate care and reinvest savings in further reform.

Another big effort was unveiled in late 2014, when Governor Cuomo announced that the state had received a nearly \$100 million, four-year State Innovations Model (SIM) grant from the Centers for Medicare & Medicaid Innovation. The grant will support the governor's State Health Innovation Plan (SHIP) to integrate primary care, achieve better outcomes, facilitate payment reform, improve access to high-quality primary care, and provide more information to patients. Other initiatives include investments in health care IT, expansion of the Statewide Health Information Network for New York (SHIN-NY), and an effort to launch an all-payer database, which would greatly increase the available data on payments and quality.

New York should not stop there. For one, it needs to harness the purchasing power of its army of 250,000 public employees¹¹ to win

reimbursement, delivery system, and insurance reforms with the goal of improved health and outcomes. It must encourage its counties and municipalities—notably, New York City, with its more than 300,000 (non-teacher) municipal workers¹²—to do the same.

IV. What We Stand to Gain

If the Institute of Medicine is correct, 30 percent of the health care delivered in the U.S. is wasteful or ineffective.¹³ This represents a tremendous opportunity for New York to right-size its health care sector without compromising (and likely improving) the quality of care delivered.

In a highly competitive national and international business environment, New York's outsize health care spending is a headwind blocking its full potential. If the state succeeds in retooling its health care system, it will lower costs, improve care, and become a beacon for health care innovators. Numerous tech-savvy start-ups have already arrived, with ambitious agendas to reinvent everything: how health insurance functions and outcomes are measured; what it means to provide effective primary care; and how to deliver a satisfying patient experience. More broadly, successful retooling will lift some of the state's heavy tax burdens and help attract new employers, grow existing businesses, and create a more affordable environment for residents.

Fortunately, New York has many of the tools necessary to pull this off. Size, high-tech talent, and its status as the nation's media and financial capital give New York a ready platform for testing and launching innovations in consumer-directed health care. Yet reform efforts under way remain in their infancy and require further support and funding to widen their scope and availability. Legal, bureaucratic, and cultural obstacles remain, as well, and must be removed. The "New York state of mind" that equates high-cost care with high-quality care must be challenged: it simply is not true.

V. What Got Us Here: Symptoms of Dysfunction

Until recently, New York has been a laggard in health care reform for familiar reasons. Start with prices: sky-high, thanks in part to a fragmented system.

Fragmentation

Highly competitive on nearly every other front, New York, like most other states, is astonishingly accepting of huge pricing disparities in health care. Consider the following 2012 tale of two Manhattan hospitals: at the public Metropolitan Hospital, the bill for a patient discharged with a heart attack (diagnosis-related group code 280) was \$22,000; at the nearby private Lenox Hill Hospital, it totaled \$112,000.¹⁴ New York is not alone. In Philadelphia, the price of echocardiograms (ultrasound images of the heart) ranged from \$700 to \$12,000, according to the *New York Times*.¹⁵

On numerous health care–related costs, New York spends more than most other states. ESI runs about 11.5 percent higher than the national median.¹⁶ In 2012, a typical ESI family plan in New York cost some \$17,000 annually, according to the Medical Expenditure Panel Survey, among the country's most expensive.¹⁷ A 2013 Robert Wood Johnson Foundation report rated New York among the five most expensive states for family-sponsored coverage.¹⁸

New York's public programs are unusually pricey, too. The Kaiser Family Foundation found that the state's Medicaid program spent nearly 60 percent more than the national average across all enrollee groups in 2011 (the last year for which comprehensive data are available) and nearly 30 percent more for nondisabled adults.¹⁹ Although the federal government pays for half of the program (and 90 percent of the ACA's Medicaid expansion population), Medicaid costs undoubtedly contribute to New York's soaring tax burden—fifth-highest in the country, according to the Tax Foundation.²⁰

New York's unusually high costs are explained, in part, by the fact that its medical landscape is marked by fragmentation and little vertical integration, which means few incentives for providers to control expenses. Certain other states, by contrast, have large medical groups and integrated systems, such as Kaiser Permanente. Located in California, Colorado, and Georgia, among others, Kaiser owns all the hospitals and employs all the doctors in its network, thereby maintaining tighter control over costs and quality.²¹

Much of Kaiser's success is often credited to its care coordination efforts. While New York's hospitals have recently begun to merge into larger, consolidated networks, the impact of this trend on cost and quality

remains unclear; to date, the available evidence suggests that hospital consolidation drives up prices without improving quality.²²

Mediocrity

Despite its high costs and reputation for high tech, New York's health care outcomes are often mediocre. Contrary to popular wisdom, there is usually little correlation between the size of a medical bill and the success of the care performed: some of the most expensive U.S. hospitals and doctors have poor outcomes, and vice versa.²³ New York, in other words, may be home to some of the world's most prestigious medical institutions, though not all such institutions deliver world-class outcomes.

The Leapfrog Group, a Washington-based nonprofit, collects data from more than 2,500 U.S. hospitals and assigns them letter grades for safety (see Chapter 3). In its 2014 report, Leapfrog assigned its highest grade (A) to only 20 percent of New York's hospitals.²⁴ Some famous New York hospitals—Beth Israel, Jacobi Medical Center, and New York–Presbyterian—received top marks, while others scored far lower; two received Fs. And compared with most other states, far fewer New York hospitals complete Leapfrog's voluntary survey.²⁵

Opacity

New York's culture of opaqueness aggravates its fragmented delivery system. Despite nascent transparency efforts, little remains publicly known about the state's health care outcomes and costs. Some large insurers—notably, Aetna, Anthem, Cigna, and UnitedHealthcare—offer transparency tools to their customers, revealing prices negotiated with doctors, hospitals, and other providers.²⁶ For the general public, however, precious little information is available on pricing, safety, and outcomes for hospitals—and what is available is often difficult to access. The same is true for physicians.

In states such as California, Maine, Massachusetts, Minnesota, and Wisconsin, on the other hand, independent quality data on medical groups are available. There, data are collected, by law, from health plans and reported in aggregated form on public websites. In 2007, the New York Quality Alliance, a project launched by the New York Health Plan Association with the help of my organization, was awarded a state grant

to explore this approach. But when long-term funding was sought from health plans, the response was mixed and the project discontinued. Cost transparency provided by FAIR Health—a national nonprofit that aggregates claims data from health plans and provides cost information on various services—is a good start.

Clearly, absent the right data, it is difficult to encourage competition based on quality among providers—and virtually impossible for patients, payers, and employers to make informed choices. Adding to the present murkiness, contracts in New York between plans and providers often include anti-steering and anti-transparency language, limiting the ability of plans to direct members to higher-quality and/or lower-cost providers, or to disclose the prices of specific services (or even the basis for such prices) to consumers and other providers.

Reluctance to Innovate

New York has failed to fully leverage its considerable size to win concessions from insurers and providers. With its 250,000 state employees and 6 million Medicaid enrollees,²⁷ New York has two big levers with which to drive reimbursement and transparency reforms.

While it has certainly started to harness the power of its Medicaid system, New York has been reluctant to follow the lead of others in the private and public sectors by aggressively behaving as a value purchaser with respect to its labor force.²⁸ New York has also been slow to adopt HSAs. These tax-advantaged plans, as noted, often accompany high-deductible insurance coverage, lessening the latter's sting. Nationally, about 10 percent of privately insured patients are covered by HSAs; New York's share is 5.4 percent.²⁹

In New York, as elsewhere, nascent efforts to improve transparency in health care quality and cost have largely focused on hospitals, not on care provided by physicians.³⁰ It is widely believed that patient health would benefit from early, consistent care at the primary level, avoiding the need, in many instances, for far more complicated treatment in hospitals. It is therefore critical that health care consumers have better information on the cost and quality of primary-care services.

In 2011, Massachusetts offered state employees three months of free premiums if they switched to narrow-network plans (which offer a

limited number of lower-cost, high-quality providers). A recent evaluation of the initiative found that those who took up the plans increased primary-care usage, reduced the use of specialists, and spent 36 percent less on health care compared with those who did not opt for the plans—all with no adverse effect on health outcomes.³¹

VI. Without Faster Reform, New York's Prognosis Is Poor

New York has little choice but to speed up change. If it does not do so, its physical and financial health will suffer considerably. In 2010, New York City alone incurred \$9.4 billion in retiree health care obligations;³² spending on employee health insurance, net of premiums, was over \$2 billion.³³ The state's high cost of care (11.5 percent above the national median) is responsible for a growing share of compensation being shifted to benefits, rather than wages. For state and local governments, this limits the ability to invest in other sectors, attract business investment, and grow tax revenue.

Employers and government managers are not the only ones who will feel the pain if change does not arrive rapidly. Providers and insurers will be affected, too. As the ACA takes hold and the Cadillac tax looms larger, the search for high-quality, lower-cost care will quicken. Health care, once a largely local service, is starting to take flight. Its parameters are expanding, regionally, nationally, and globally: through the Internet; direct contracting between employers and centers of medical excellence, such as the Cleveland Clinic; telemedicine; and medical tourism, including travel surgery networks.

As the next generation of diagnostics and big-data analytics come online, health care's focus will shift away from the hospital and labor-intensive services at which New York providers excel, in favor of disease prevention and management provided remotely and monitored through wearable diagnostics. In California, for example, Kaiser Permanente already conducts nearly 30 percent of physician office visits virtually (i.e., by computer, phone, or other digital means).³⁴

New York residents will no longer have to be New York patients: they can seek treatment elsewhere or be treated virtually. Conversely, out-of-state and foreign consumers might no longer flock to the most prestigious New York hospitals if alternatives

provided excellent, transparent, and competitive care. New York can prepare for the future of medicine—personalized, data-driven, and competitive—or be left behind.

VII. Opportunity Beckons

The future of medicine is fast becoming its present, thanks in part to the adoption of direct contracting for health care—for specific services or a broader program, and tying performance to fees—by some of the nation's biggest companies. Lowe's has worked with the Cleveland Clinic, famed for price and quality transparency, to bundle heart-surgery costs (including travel and lodging) for employees. Walmart has a contract with six health systems spread across the U.S., including the Mayo Clinic and Geisinger, to provide heart, spine, and transplant surgeries for employees.³⁵ Fixed rates offer hospitals strong incentives to deliver strong outcomes: cost-effective care leads to higher profits.

That New York has begun to change its health care ways on certain fronts is good news. And if its challenges are greater than those of many other states, so, too, are its potential gains from reform. As an employer, the state can play a central role in driving change by adopting tools embraced by other large employers. History suggests that doing so would not only put downward pressure on public-sector health care costs; it would also reduce private-sector costs, as large and small businesses followed the state's lead.

Thanks to promised improvements in SHIN-NY, plans to institute an all-payer database, various initiatives in the just-awarded SIM grant, and the growing opportunity to link genomic and phenotypic data with clinical data, New York might even position itself to become a "Silicon Valley on the Hudson." The goal? Empower consumers, through data-driven, entrepreneurial business models that identify the most innovative care at the most cost-effective price.

HDHPs can, as mentioned, get consumers engaged in their health care; but unlocking HDHPs potential and that of third-party transparency services will require much greater access to real-time data on provider pricing, quality, and outcomes. New York will have to become far more assertive in challenging large hospitals—insisting on provisions that guarantee transparency and incorporate far-reaching payment reforms,

including cost savings and quality benchmarks, as well as coverage that is fully capitated. Private-sector employers of all sizes could then use the state's aggressive plans as templates for their own contracts.

VIII. The Path Forward

1. Harness city and state governments' purchasing power.

Like the California Public Employees' Retirement System (CalPERS), Albany could claim a pivotal role in health care because it is a large purchaser of health benefits for Medicaid recipients and state employees, retirees, and their dependents.

No matter their size, private-sector employers lack the critical mass to win major changes in a state as large as New York. The state's business is, however, large enough for Albany to lay claim to many of the innovations won by other purchasers around the United States. (A coalition like Northeast Business Group on Health can organize private-sector employers and harness their purchasing power to augment that of the state.)

Though it might be politically challenging, the state might make its employees active purchasers by offering consumer-directed health plans and HSAs, among other plans, along with transparency tools. (See box, "Castlight's Transparency Tools," and Chapter 5's discussion of how the Federal Employees Health Benefit Plan and other public exchanges hold down costs and offer high-quality care.) New York is well positioned to pioneer unique payment methods, as CalPERS has done with reference pricing in California. (See box, "What Is Reference Pricing?")

Direct contracting is another promising approach: some of the biggest U.S. employers have opted for this approach, on a national level, where their clout is cumulative, or in smaller markets, where they have a large population. Here, New York can identify the most expensive conditions and procedures for current employees and retirees, and design reimbursement models that reward providers for the best outcomes for a competitive fee. Bidding should include in- and out-of-state providers. Once "proof of concept" is established, public and private employers should continue to bundle fees for other conditions.

Semiconductor giant Intel deploys direct contracting. In 2013, Intel capitalized on its large presence in Rio Rancho, New Mexico, where

Castlight's Transparency Tools

Based in San Francisco, Castlight Health provides employers around the U.S. with various online tools that tap in to what it calls "the industry's most comprehensive and diverse database of health care pricing, quality and outcome[s]." ³⁶ Employers, in turn, use these tools to "empower employees to make informed health care choices with a clear understanding of costs and likely outcomes." Castlight's tools reveal how widely prices vary for the same service—across the country and even down the block.

it employs about 3,500 people at a manufacturing plant, to sign a direct contract with Presbyterian Healthcare Services to give its workers "more personalized, evidence-based, coordinated and efficient care."³⁷ Under this arrangement, Presbyterian earns a bonus if it meets certain quality and cost goals—and pays a penalty if it does not. (Some providers, such as Geisinger in Pennsylvania, offer warranties on certain surgical procedures—another reimbursement reform that New York should demand.) Intel's Rio Rancho employees can choose other providers but will pay more for the privilege.

Innovative tools can be combined with such efforts to further improve outcomes. Consumer Medical Resources, Best Doctors, and other advisory-service firms offered by employers and health plans allow patients to request second opinions through a network of experts. With as many as one in 20 U.S. patients misdiagnosed, according to a recent *BMJ Quality and Safety* study,³⁸ the potential for better outcomes and cost savings is considerable.

New York should leverage its power to increase transparency, too. When approving plans for state employees, for instance, it could provide a relatively high deductible (say, \$500 or more) for hospitals that do not complete the Leapfrog survey or provide similar data. Maine successfully pursued this strategy with its employee benefit plan.

Moving state employees to new forms of coverage may encounter resistance. New York should learn from CalPERS, which provides coverage for the largest group of state employees in the U.S.: start the shift with the retiree force, concentrating on chronic conditions, before addressing active employees. New York mayor Bill de Blasio's agreement with the Uniformed Superior Officers Coalition—making raises contingent on retiree health care savings—is a step in the right direction. Such contracts should go further by explicitly including tools like bundled payments and reference pricing.

What Is Reference Pricing?

Employers establish fixed prices for given services, and then offer employees various providers, vetted for quality, which are willing to accept the employers' fixed prices. Employees, in turn, can select a suggested provider or one of their choosing to perform the service—at a fixed price or higher amount. If the latter, the employee pays the difference.

To encourage active state employees in New York to switch to value-based care, Albany could make contributions to employee HSAs and experiment with value-based insurance designs that hold employees harmless (that is, total benefits provided can be equivalent when paired with a compensating HSA contribution) when they use high-value providers. As for wellness programs, which have a mixed track record, the size and tenure of government workforces—average tenure is nearly double that of the private sector³⁹—may provide the scale needed to demonstrate whether such efforts can be consistently successful. Disease-management programs that offer benefits for quitting smoking, weight control, and healthy cholesterol levels should certainly be increased.

New York City's latest contract with the United Federation of Teachers calls for significant savings in return for higher wages. Ensuring that such savings are actually achieved (the details remain unclear) will require public employers and unions to consider novel benefit designs—perhaps through value-based insurance or reference-pricing options. Though the city's contract represents a welcome first step, much more progress can clearly be achieved.

New York has more than its workforce to leverage. It has, as mentioned, begun to use its mammoth Medicaid program to transform delivery systems. The ambitious DSRIP program, for example, supports the creation of Performing Provider Systems (PPS), structures that integrate and coordinate care among multiple organizations to achieve specific clinical improvements for targeted groups of Medicaid patients. These improvements will pay off in large savings that the state will then reinvest in other innovations to improve care delivery. DSRIP, or something similar, can be leveraged to address chronic illnesses like obesity and cardiovascular disease in the state's public and private workforce. And, as in the private sector, Medicaid enrollees should be rewarded for healthy behavior that reduces risk of complications from diabetes and other chronic illnesses.

2. Undo anti-steerage and anti-transparency provisions.

While Albany must insist on transparency in the coverage it obtains for its workers, it should adopt legislation fostering transparency for private-sector workers, too.

Anti-steerage and anti-transparency language is a fixture of contracts between providers (often hospital systems) and payers. Such provisions prohibit payers from doing anything to steer patients away from, say, a particular hospital system and toward a tiered-benefit structure with different co-pays for different hospitals (thereby giving patients the means to find low-cost, high-quality providers). Such provisions also prohibit payers from releasing cost and price data.

One reform, enacted in Massachusetts, required every plan to offer at least one tiered-network option and effectively made anti-steerage language illegal.⁴⁰ Alternatively, plans could be required to disclose which providers required anti-steerage language in their contract—a “name and shame” strategy.

Transparency of a different variety is necessary for tiered-benefit structures created by health plans. At present, tiered arrangements can vary dramatically, with widely divergent, often unclear, ranking systems. Fixing this need not require legislation—the current multitude of hotel- and travel-ranking systems, for instance, exists because the data are freely available.⁴¹ Liberating health care quality and pricing data would, likewise, spur innovators to build systems to present data to patients in the same way, say, that Kayak does for travelers. Here, the New York State health insurance exchange could be a pioneer, a “health care Yelp,” allowing enrollees to post reviews of health plans and physician networks directly on the exchange website. The exchange should also post hospital safety scores, such as those created by Leapfrog.

3. Hail the disrupters.

Despite roadblocks, health care “disrupters” have arrived in New York, armed with new ideas and powered by the latest technology.

Whether reinventing primary care (One Medical Group), health insurance (Oscar Health Insurance), the patient experience (Sherpaa), or data analytics (Artemis), these start-ups are having an impact on the

state's health care conversation and landscape. (See box, "Four New York Disrupters.") New York's historical role as a melting pot is an asset, for it retains the ability to attract high-tech thinkers, entrepreneurial doctors, and committed investors who correctly sense that serious change in health care is the next big opportunity.

4. Support technology.

Technology is providing numerous opportunities for disruptive innovation in health care. Telemedicine, for example, has the potential to arbitrage local, regional, and national price and quality disparities for services that can be standardized. While New York requires Medicaid to cover telemedicine, other New York laws make telemedicine difficult, requiring out-of-state providers to be licensed in-state.⁴² (The solution is straightforward: licensing reciprocity with other states.)

As noted, public and private sectors must work to ensure publicly browsable state databases on health outcomes, cost, and quality. To produce meaningful long-run change, increased transparency and broader access to cost and outcome data will have to be presented in consumer-friendly formats. New York's business and investment communities are already focused on supporting health care technology startups, especially through New York's Digital Accelerator. Mandating open databases and networks would—in addition to other benefits—entice more private investment into the sector. (See Chapter 4 for more on technology and health care reform.)

5. Cooperate on payment reform.

Providers and insurers must work harder on payment reform, ensuring that reforms are focused on health outcomes, not on process indexes. Identifying low-hanging fruit requires opening up currently inaccessible data, while encouraging providers to compete on cost and quality.

Throughout their working lives, many employees will likely transition between employer-based coverage and public and private exchanges. Adopting pro-competition reforms across New York's various health care markets will create widely beneficial synergies.

Four New York Disrupters

The following four firms are prominent examples of the disruptive innovation that is changing New York's health care landscape for the better.

One Medical Group

Founded in 2007 by Dr. Tom X. Lee, One Medical provides a new model of primary care. With 90 doctors in six markets around the country, including New York, the company uses a smartphone app to marry virtual and face-to-face care. Patients pay \$150-\$200 annually, on top of their regular insurance. In return, they can schedule same-day appointments, receive test results, request prescriptions, view medical records, and consult doctors in person when advisable—but otherwise receive care via phone or e-mail. (Only around 10 percent of traditional primary-care physicians currently use e-mail to communicate with patients, according to Lee.) Such heavy reliance on virtual care, and the resulting efficiencies, means that doctors at One Medical have more time to spend on fewer patients, typically handling half the daily volume of many primary-care doctors.

Oscar Health

Launched in 2013 by three friends who met in business school, this start-up marries technology with health care insurance. Subscribers get a raft of cutting-edge online tools, including a search engine that provides answers to medical questions and a ranking system for nearby in-network providers. Subscribers also get to compare prices charged by network doctors for various services. Those who wish to talk directly with a doctor are promised callbacks within an hour after making a request online. Phone exams are often a cost-efficient substitute for emergency-room visits, observes cofounder Mario Schlosser (see Chapter 4), though they are not meant to replace face-to-face visits for serious issues or ongoing treatment.

Sherpaa

Akin to a concierge service piggybacked onto a traditional insurer, Sherpaa is designed to radically improve patients' health care experiences by offering 24/7 telephone access to physicians and follow-up help to deal with insurance issues. Founded in 2012 by Dr. Jay Parkinson and Cheryl Swirnow, Sherpaa costs employers about \$30 a month per employee—an expense employers hope to recoup many times over through reduced claims and, eventually, lower premiums. Employees pay no extra charges for using the service. Sherpaa's doctors, selected for their quality and efficiency, are paid slightly more than nearby primary-care physicians. (Most staff doctors are based in New York City, but the company also operates in California, Illinois, and New Jersey.) The service is 100 percent virtual, with some 70 percent of problems resolved (i.e., answered questions and filled prescriptions) during phone consultations, says Swirnow, with the rest referred to external specialists.

Artemis

Founded by Grant Gordon in 2013, Artemis is a health-analytics platform for self-insured employers, offering tools to sift through mountains of information—health and prescription claims, biometric data, wellness data, and more—to reveal patterns, trends, and key cost drivers. By separating helpful and unhelpful data, employers can observe where present and future savings can be realized. Change requires measurement, Gordon says, and Artemis provides the customized benchmarks to produce metrics that reveal insights and track return on investment.

Conclusion

Long a health care reform laggard, New York is now poised to join the reform fast track, prodded in part by DSRIP and the nearly \$100 million SIM grant. To sustain the current momentum, employers and consumers must keep demanding reform and innovation from the state's public and private sectors.

As costs shift to consumers, we need to ensure that consumers have the information required to make smart choices. Entrepreneurs can facilitate such efforts. SHIN-NY must gather and share more data. The goal: a “health care Carfax,” where consumers can find the right health care “dealer” in a few clicks.

New York has arrived at a major intersection. If the state's public and private employers sustain pressure on providers and insurers to become consumer-focused and competitive, various positive reforms will follow, incentivizing disrupters to create new tools and services—including retail health clinics, telemedicine, and value-based insurance—that displace inefficient providers. In the process, New York will emerge as a national leader in providing the best care at the best cost—to New Yorkers, other Americans, and patients worldwide.

If, on the other hand, we accept New York's expensive, siloed, health care status quo, consumers, employers, and taxpayers will face mounting costs for mediocre outcomes. As other states innovate, “more for less” will be New York's health care legacy. Which path will the Empire State choose?

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Bringing Effective Competition to New York's Health Care System

Joseph Antos, *American Enterprise Institute*

Introduction

The New York State health care system has both an opportunity and a pressing need to transform itself into an efficient, high-performing system that offers top value to consumers. The state's providers excel in many ways: Memorial Sloan Kettering is among the best cancer treatment centers in the world, for example, and New York Presbyterian is consistently ranked among the top ten U.S. hospitals.¹ But the cost of health care in the state has long been among the most expensive in the country, and performance has lagged in many other key respects. Fortunately, New York can build on changes that are already under way to bring the state to the forefront of health care in the nation.

This is certainly no time for federal or state policymakers to consider America's health care spending problem "cured." Despite the recent slowdown in health spending growth, rising costs continue to impose an ever-larger burden on employers, consumers, and taxpayers. In 2015, New Yorkers will spend \$234 billion on health care—about one of every six dollars produced in the state.² Unless action is taken, health spending in New York State is projected to grow to nearly \$320 billion by 2020, rising by more than one-third in a mere five years.³

Nationally, the cost picture is equally bleak. The actuaries at the Centers for Medicare and Medicaid Services (CMS) project that national health spending will grow from \$3.2 trillion in 2015 to \$4.3 trillion in 2020, reaching \$5.2 trillion by 2023.⁴ Health spending will increase from 17.6 percent to 19.3 percent of GDP over that period.

The impact of high and rising costs extends beyond the burden placed on family budgets by insurance premiums and copayments for

health services. Unpredictable health care cost growth has made it difficult for employers to plan for future hiring and business expansion. Employees' wages have stagnated as a growing share of worker compensation is devoted to covering the cost of health insurance.

Rising health costs also limit the ability of government—federal, state, and local—to finance education, social services, housing, and other critical policy priorities.⁵ Over the next decade, the federal government will spend a total of \$14.6 trillion for major health programs (including Medicare, Medicaid, subsidies for insurance through the exchanges, and the Children's Health Insurance Program), making health care the largest single category of spending in the budget.⁶ Left unchecked, federal health spending and interest on the debt is expected to consume every dollar of federal revenue by 2089.⁷

The fiscal impact of health care on state and local government budgets is equally serious. In 2012, state and local governments paid \$475 billion for health care.⁸ The state share of Medicaid alone accounted for \$189 billion, and contributions to employee and retiree insurance accounted for \$153 billion. The remainder was used to finance state and local health departments and other health programs (including the Children's Health Insurance Program, school health, and maternal and child health programs).

New York has the nation's third-largest public retiree health plan, with \$250 billion in unfunded liabilities at the state and municipal levels.⁹ Because these expenses are incurred on a pay-as-you-go basis, taxpayers must bear the full cost of past promises made to retirees. Annual costs for current employees are ramping up as well, with about \$2 billion in expenditures for state employees in 2013.

Despite the high price tag, it is widely recognized that Americans do not get enough bang for their health care buck. The Institute of Medicine estimates that 30 percent of health spending is wasted or misused.¹⁰ Unnecessary services and inefficiently delivered care account for about half of the unnecessary spending. High administrative costs, fraud, and failure to adopt preventive health measures also contribute to the excess cost.

States that, like New York, spend the most for health care do not obtain substantially better performance than states that spend less. In 2009, New York was the sixth-most expensive U.S. state, measured as

health spending per capita; over the previous two decades, the state was the third- or fourth-most expensive.¹¹ Yet the Commonwealth Fund's 2014 State Scorecard ranks New York 19th in the nation on the overall quality of its health care system. New York was ranked 36th on potential-ly avoidable use of hospitals and cost of care, 17th on access and affordability, and 12th on healthy lives.¹²

The mismatch between health spending and value produced by the health care system is stark and long-standing. Health care has largely failed to adopt new, more efficient, user-friendly ways of delivering better services at better prices. In contrast, other industries with consumer-focused business models have been able to improve their products and services while keeping cost in check. The smartphone in your pocket, for instance, is more powerful and costs less than a large desktop computer did a decade ago.

Effective competition is the missing ingredient in American health care, for competition promotes quality improvement and cost-saving efficiencies that benefit consumers. Tight government regulation and misguided payment policies discourage the entry of new health plans and adoption of new ways of delivering services.

Fostering true competition is not a matter of simply counting noses. In well-functioning markets, consumers have a choice of firms supplying the product. They also have the necessary information and control over resources so that their preferences and purchasing decisions drive the market.

Indeed, New York has an abundance of hospitals and insurers but very little effective competition on the basis of cost and quality. Consumers—and even many payers, such as large self-insured corporations—have little or no ability to compare the price and performance of different providers. In the absence of such information, inefficient providers can charge higher prices than otherwise possible, and unsafe practices are likely to continue.

These are conditions that have long been the rule in the health sector because of the failure to foster effective competition. In contrast, household names in the 1970s in the consumer electronics industry—including IBM, Texas Instruments, and Hewlett-Packard—were forced to radically change their business models and eventually lost out to more nimble competitors like Apple, Microsoft, and Google. While the technology

inside hospitals has changed, their structure and business model have remained largely unchanged and unchallenged for most of the last half-century, thanks in part to rigid regulation and perverse financial incentives at the state and federal levels.

Major reforms are needed to promote effective competition among health industry stakeholders and to shift the health sector to a focus on the consumer. To be sure, federal health policy—including the Affordable Care Act (ACA), rules governing Medicare and Medicaid, tax provisions, antitrust activities, and other federal regulatory actions—plays a dominant role in shaping the way much of the health system operates. But within that context, New York's citizens, employers, legislators, and regulators can pursue an important pro-competitive agenda to make the state's health care more efficient and effective and less expensive.

I. Why Competition Matters

Health care in the United States is an amalgam of public and private financing for services that are largely provided by private hospitals, physicians, and other practitioners. At its best, American health care is the best in the world. But much of our care falls short of that ideal, and all of it is expensive.

The rising cost of health benefits has largely absorbed the funds that would otherwise have resulted in higher cash wages for workers, threatening the ability of families to pay for care while meeting other obligations. Federal, state, and local budgets are also feeling pressure from the rising cost of health care, drawing away spending from other priorities. The cost of health care is seen in high insurance premiums, large deductibles and copayments, and high fees. It is also hidden in reduced wages, higher taxes, and restrictions on what consumers may buy.

Despite unparalleled levels of health spending, tens of millions of Americans lack insurance coverage for lengthy periods of time.¹³ Even with expanded access to insurance through the ACA, there are likely to be some 30 million uninsured people once the reform takes full effect;¹⁴ 1.7 million New Yorkers are expected to remain uninsured even after full implementation.¹⁵ Moreover, the care that people receive too often fails to yield improvements in their health and well-being commensurate with the trillions we pay.

Increased competition is the key to resolving these problems. Competing manufacturers and suppliers aggressively seek ways to trim unnecessary costs and improve their products to attract a larger share of the market; in some cases, they create entirely new markets. Online retailers such as Amazon created a more convenient way to shop for many consumers that would not have been identified if we were limited to sales in brick-and-mortar shops. Competition is vigorous in many industries, resulting in lower prices, a wider variety of products, and greater innovation.

Competition is the exception, not the rule, in American health care, although that may be changing. After a failed attempt in the 1990s to control health benefit costs by shifting to restrictive managed care plans, many employers now offer a choice of high-deductible insurance in addition to more traditional types of health plans. The rapid adoption of high-deductible insurance plans is a significant factor driving the slowdown in health spending over the past decade.¹⁶ More realistic choices, with out-of-pocket prices reflecting the true cost of health services, caused workers to reevaluate what they wish to purchase and how much they wish to pay.

Medicare's Part D prescription drug benefit offers a rare glimpse of competition in U.S. health care. Seniors have a wide range of coverage choices from competing plans, allowing them to select better coverage at lower cost. In 2012, actual program costs were 57 percent lower than CBO projections, partly because of the impact of competition and consumer choice.¹⁷ Aggressive negotiation between Part D plans, pharmaceutical manufacturers, and pharmacies have created incentives to promote greater use of generic drugs, keeping costs down.

Perhaps more important, consumer satisfaction with the Medicare Part D program is consistently very high. A 2007 AARP survey—shortly after the program launched—found that 85 percent of Part D beneficiaries were satisfied with their drug plans, and 78 percent felt that they had made a good decision.¹⁸ Satisfaction remains (as of 2013) at, or above, 90 percent, including for low-income seniors eligible for additional federal subsidies.¹⁹

In 2014, more than 37 million Medicare beneficiaries enrolled in Medicare drug plans, an increase of 2 million since 2013 and 15 million since 2006.²⁰ Although Congress specified a standard-benefit

package when it enacted Part D, it gave the plans flexibility to innovate. In 2015, no plans use the standard benefit design, but all plans offer benefits valued at least as much, with 55 percent of the plans offering extra benefits.²¹ The base premium in 2015 is \$33.13 per month, a 2 percent increase over the previous year. The program's costs (measured per enrollee) have risen, on average, by 2.3 percent annually between 2006 and 2013, well below other health care costs.

The Part D experience demonstrates that a well-organized competitive market in health care will work. Plans found enough customers to make the coverage affordable and attractive while remaining sufficiently profitable to operate over the long term. This was accomplished without going back to the taxpayer for ever-increasing subsidies and without needing a government-run plan to fill in if private plans chose not to compete.

II. Why Competition Remains the Exception

Health care consumers are ready for a change. A PricewaterhouseCoopers survey found that consumers want a better experience with their providers: better access to information (including online and mobile applications), more convenient access to services, and better communication during the visit.²² They also want better information from insurers and faster claims processing. Consumers want the health system to better respond to their needs at an affordable price.

Encouragingly, change *is* occurring in the U.S. health system, and more is to come. Rising costs have led employers and insurers to develop health plans that give consumers greater say in what they buy and how much they pay. The ACA's "Cadillac tax," a 40 percent excise tax on the value of employer-sponsored plans that exceed a threshold amount, has added to the pressure to adopt lower-cost health plans; that pressure will persist regardless of how the courts may rule or how Congress may seek to change provisions in the law. These forces are reshaping how consumers and patients interact with the health system. Indeed, employers have already begun to respond by trimming back the generosity of their health coverage.²³

Government insurance exchanges also bring more health plan choices to consumers who do not have access to insurance through work.

Narrow provider networks and higher out-of-pocket costs, including high deductibles, are becoming adopted widely on state exchanges, including New York's. They require consumers to shop carefully for the plans that best fit their families' needs. Whether they have employer-sponsored insurance or purchase coverage on the ACA exchanges, consumers will increasingly need to assume more responsibility for the plans they choose and health care received. The question is thus: Will we create a competitive environment where innovative providers and insurers are driven to provide the tools and information that consumers require to make the best decisions for themselves and their families?

We have made real progress but are not yet headed toward a fully competitive, consumer-friendly health system. Formidable roadblocks remain to reforming a system that is neither highly competitive nor highly responsive to consumer demands. Numerous factors that prevent competition from taking hold more broadly in the American health care sector are, nevertheless, amenable to reform from policymakers in New York.

How we finance health care discourages competition

Because of substantial tax benefits, the majority of Americans in the health insurance market have long preferred to purchase coverage through employers rather than on the open market. Premium payments made by workers for their employer-sponsored health insurance are excluded from their income for tax purposes. In 2014, this exclusion is estimated to save families more than \$300 billion in federal income and payroll taxes.²⁴

The tax exclusion is available only through one's employer, discouraging workers from considering other sources of coverage. This reduces the size of the individual insurance market and reduces the scope of competition among insurers. The subsidy also encourages workers to buy more generous health insurance with low deductibles and other cost-sharing requirements, masking the true cost of health services and encouraging greater utilization than otherwise.

Traditional health insurers pay physicians, hospitals, and other providers on a fee-for-service basis. This means that the provider receives additional payments for delivering additional services, regardless of whether the service is an essential part of the patient's treatment. Providers under

this system have strong incentives to provide more services; generous coverage, with low out-of-pocket costs, reduces consumer concerns about unnecessary costs. These financial incentives have played a major role in the rapid rise of U.S. health care spending.

Because of growing concerns about cost and performance, alternative financing arrangements have become increasingly popular. To create more cost awareness among consumers, employers are increasingly offering high-deductible health plans linked to a health savings account (HSA) for medical expenses. Account-based plans give consumers more direct control over, and more responsibility for, their health spending.

America's Health Insurance Plans (AHIP) reports that enrollment in HSA-qualified high-deductible plans has grown from 3.2 million people in 2006 to 17.4 million in 2014.²⁵ Across the nation, about 10 percent of people enrolled in commercial health insurance participated in such plans. New York is well below that level, with 5.4 percent of the state's commercial insurance enrollment in HSA-qualified high-deductible plans.

This is, however, likely to change because many of the plans offered on the ACA's insurance exchanges are also high-deductible, although the law does not authorize a savings account to help enrollees cover their out-of-pocket costs. An analysis of health plans offered in 2014 on the 34 federally facilitated insurance exchanges shows that average deductible amounts for bronze-, silver-, and gold-level health plans are all above the Treasury's definition of "high deductible."²⁶

Employers are trying other approaches to slow rising health costs and improve outcomes. There is increasing interest in shifting from fee-for-service to payment for an episode of care ("bundled payment") and other performance-based payment methods. The Pacific Business Group on Health has developed a "centers of excellence" program that negotiates bundled payments with high-quality health centers, focusing first on hip and knee replacements.²⁷

Less progress has been made tying payment for services to measures of quality or outcomes. Typical pay-for-performance systems provide a bonus to providers that meet or exceed agreed-upon quality or process measures. There are more than 40 private-sector pay-for-performance programs and numerous other federal initiatives.²⁸ However, the technical challenges are substantial, and only a small percentage of health services have payments tied to performance measures.

Private insurance exchanges—which could give workers more health plan choices than the typical employer plan—are attracting interest, though their impact on cost remains uncertain.²⁹ Employers are also adopting a defined contribution approach, with increasing interest in shifting to a private exchange rather than continuing to offer only one or two insurance options. Rather than paying for more expensive health plans, a fixed employer premium contribution gives workers a strong incentive to select lower-cost, higher-value plans while allowing them to purchase more expensive plans if they wish.

Nonetheless, the push to base contracts on outcomes—and not just process metrics—should remain a critical focus for New York’s employers, public and private. Process metrics can be easily manipulated and can encourage the very type of overutilization that has long defined fee-for-service health care. By using analytics to map relationships between conditions, treatment pathways, and outcomes, policymakers can focus their efforts on creating bundled payments for complex services, which can promote care coordination. By focusing on outcomes and total costs, purchasers can remain agnostic about exactly how to achieve those outcomes, or who is most capable of delivering them.

Payment reform can discourage the fragmentation and overutilization that has defined fee-for-service contracts to date, while encouraging innovation and competition in the delivery of care to consumers. Liberating the market for new competitors to challenge incumbents around these types of contracts is the next critical step—thereby generating synergy for other reforms like reference pricing, direct contracting, value-based insurance design, and health savings accounts or consumer-directed health plans.

Health care cost and quality information is typically unavailable to consumers

For competition to be effective, consumers need to know what they are buying and what it costs. Those conditions are difficult to satisfy in health care.

At present, consumers rarely know what they will pay in advance of medical treatment. The cost they pay out of their own pockets depends on the nature of the service, the terms of their insurance coverage, and who provides the care. For many routine services, such as a physician office visit,

insurance typically charges a standard copayment, such as \$20. But if the consumer has not yet met the insurance deductible, which must be paid before the insurer pays its share of a medical bill, the routine visit might require a much larger payment. If the health care provider is not in the preferred network, the out-of-pocket cost paid by the consumer could be substantially higher.

The situation is even more complicated if the consumer receives more complex services, such as surgery performed in a hospital. A few health systems, including Geisinger Health System, based in central Pennsylvania, and Baptist Health South Florida, help consumers estimate their out-of-pocket cost.³⁰ They are the exceptions.

In most cases, a consumer knows what the charge is only after the hospitalization, and that figure can be shockingly high. It is increasingly common for high-cost medical consultants and other hospital employees to look in on a patient and generate a hefty fee, a practice sometimes called drive-by doctoring.³¹ Typically, the consumer has no idea what went into a complex treatment without looking at a detailed bill.

Cost information is not the only thing missing. Information on provider quality is largely inaccessible to a typical patient. Many public and private organizations report quality metrics for physicians, hospitals, and other providers. While such reports can offer a great deal of technical data, the information is difficult to interpret and means little to most consumers.

The Medicare program offers comparative information on physicians, hospitals, nursing homes, home health agencies, and dialysis facilities.³² The most comprehensive information on provider performance is available from Hospital Compare, which reports quality measures related to the treatment of Medicare patients for heart attack, heart failure, pneumonia, and surgery for all U.S. acute care hospitals.³³

The ACA requires additional public reporting of provider performance on cost, quality, and other measures, and many states have their own reporting programs. Other groups—including the National Committee for Quality Assurance, National Quality Forum, Leapfrog Group for Patient Safety (created by employers), and Informed Patient Institute—produce report cards on plan and provider performance.

This explosion of complex technical data has not had much impact on consumer choice of health care providers. It remains very difficult to

make meaningful comparisons of performance across different providers. How well providers follow clinical protocols and the degree of patient satisfaction are certainly relevant considerations. But we also care about the improvement in patient well-being resulting from the services rendered, and that rarely can be attributed solely to the efforts of a single provider.

Consumers are interested in whether the health care provider will do a good job, the effect of care on their health, and cost. Yet consumers often cannot find even the most basic information to help make potentially life-changing decisions about their health care.

Current health care regulation discourages competition

Government regulation is a fact of life in health care. Regulation is often characterized as promoting orderly markets and protecting consumers, but excessive regulation can protect vested interests, limit market innovation, and reduce value to consumers. Regulation can provide benefits to society, but at a cost.

Health care regulation imposes a substantial burden on the economy, both in the direct cost of implementing and complying with the regulation and in the restrictions on business activity that result. One study estimated that the total cost of health services regulation exceeded \$339 billion in 2004.³⁴ This figure takes into account regulation of health facilities, health professionals, health insurance, drugs and medical devices, and the medical tort system, including the costs of defensive medicine. Allowing for some \$170 billion in benefits gained from the regulations, the net burden amounted to \$169 billion *annually*.

State actions are responsible for a substantial share of the economic burden of health regulation. More than a century of legislation and court cases have affirmed that states, not the federal government, have the power to regulate insurance.³⁵ The ACA gives the federal government new authority over the health insurance market (including mandates requiring individuals to purchase insurance and employers to offer it), but states continue to dominate the field. In addition, states actively regulate other major aspects of health care, including who may provide health services, where they may practice, and what services they may provide.

New York State's attempt during the 1990s to expand access to affordable coverage demonstrates the consequences of insurance regulation

gone wrong.³⁶ By imposing guaranteed issue (which requires insurers to offer coverage to all applicants) and community rating (which prevents insurers from charging people more based on their age or health), insurers were caught in a “death spiral.” Healthier applicants dropped out of coverage because of high premiums; as healthier people dropped out, those premiums rose higher still. By 1996, the individual insurance market in New York State was essentially wiped out.³⁷

That has since changed. The ACA’s restrictions on insurance premiums sold on the exchange are less restrictive than New York’s pure community rating (still in effect today). Under the ACA, insurers may charge somewhat higher premiums to older people and to smokers, which confers pricing flexibility not allowed under state regulation. The individual mandate also provides an incentive for healthy people to purchase insurance. In effect, the ACA opens the door for New York’s policymakers to enact additional reforms that can make health insurance more affordable for the young and healthy, better spreading actuarial risk across the entire insured population.

The ACA’s framework could give New York policymakers greater willingness to experiment with deregulatory efforts that allow for greater innovation in health insurance design and health care delivery, further enhancing the long-term viability of the individual insurance market.

Other forms of regulation favored by states impose serious costs on their citizens, too. The focus of much regulation is to limit who may provide health care in the state and under what circumstances.

Many states, including New York, use certificate of need (CON) laws to prevent hospitals and other medical facilities from entering new markets or expanding their capacity without regulatory approval. Regulators argue that CON is needed to prevent overbuilding that can increase health care costs, but there is little evidence that excessive investment in plant and equipment is reduced.³⁸ Instead of benefiting consumers, CON laws protect incumbent hospitals and health organizations and restrict competition. Political clout, rather than community need, may be the determining factor in CON rulings.³⁹

Bans on the corporate practice of medicine similarly prevent the adoption of smarter business arrangements, limit physicians’ ability to coordinate their services with other medical and nonmedical professionals, and discourage entrepreneurs from entering the health care market.

New York does not allow for-profit hospitals to operate in the state. Such regulations claim to protect physicians' ability to make independent medical judgments without conflicting business interests.⁴⁰ They also inhibit provider experimentation with different, and potentially more efficient, forms of care delivery.

However, health care has changed greatly since the early 1900s, when these regulations became popular.⁴¹ Instead of independent physicians working alone, health care is delivered in teams bolstered by expensive technologies requiring major investments. State regulation of the business of health care remains locked in the mind-set of the past century, retarding further changes that can lower cost and improve the way care is delivered.

Medical licensing and scope-of-practice laws limit who can practice medicine and what they are permitted to provide patients. Both types of regulation are intended to protect the public from unqualified providers, but they also slow the adoption of more efficient ways of delivering care made possible by improvements in medical technology and medical education. Obtaining a medical license can be costly and time-consuming.⁴² That creates a barrier to entering the medical profession but does not guarantee the competence of individual providers or guard against the loss of skills over time.

Scope-of-practice laws define the services that doctors, nurses, and other medical professionals may provide and where those services may be rendered.⁴³ Regulations have not kept pace with improvements in education and training or changes in medical technology that would enable professionals with less advanced degrees to provide care safely and effectively.⁴⁴ The oft-noted shortage of primary care providers is due, in part, to regulations preventing nurse practitioners, physician's assistants, and others from practicing at the top of their licenses.⁴⁵

III. How New York Can Promote Better Care and Better Value Through Competition

If consumers knew what health care they were really paying for, they probably would not want to buy all of it. The current financing system in the U.S. hides that cost in lower wages for workers who get their coverage on the job and higher taxes for everyone to cover the rising cost

of government health programs and subsidies for health insurance. The incentives of fee-for-service payment combined with generous insurance benefits promote greater use of services, though not necessarily better care for patients. Regulations further reinforce the status quo, reducing opportunity for upstart competitors to bring innovative approaches to market. Consumers do not know what they are paying, do not know what they are getting, and cannot know what they are missing.

New York State is a leader in the health care industry. The state hosts world-class hospital systems and renowned medical research centers that save lives daily and find new ways to diagnose and treat disease. The state is also plagued by the same problems found in health care throughout the country. The health system is expensive, hard for consumers to navigate, and resistant to new competitors that can bring fresh ideas to a major industry that has not adjusted quickly to changes in the market. New York is at a critical juncture and has the opportunity to take a number of important steps to encourage more competition in the health sector.

Employers can start by joining the growing movement toward smarter health insurance for their workers. More employers—including the state government and local municipalities, which, combined, employ about 15 percent of the 9 million workers in New York State—could offer an HSA-eligible high-deductible plan as an alternative to their current options.⁴⁶ Such a health plan gives workers more responsibility for the routine costs of care and provides tax-free savings to help pay those costs.

Employer-sponsored health insurance should also be partnered with the information tools needed to help workers get the best value from their coverage. One option is to contract with a company like Castlight Health, which provides cost information customized to each employee's health plan.⁴⁷ Large insurers—including Aetna, Cigna, and UnitedHealthcare—offer tools that allow enrollees to determine how much a specific health service is likely to cost.

As the market shifts to consumer-based coverage, information on cost and provider performance will increasingly be made available through web-based portals or smartphone apps. Basic cost calculator tools (modeled after Part D) should be built in to the state's health insurance exchange, too, along with measures of customer satisfaction.

To widen the range of health plan choices available to workers, employers can move to a private health insurance exchange, which are

run by benefits consultants like Aon Hewitt or Mercer.⁴⁸ By 2018, as many as 40 million people will be covered through private exchanges, according to estimates of industry leaders.

By bringing together a much larger group of enrollees than many employers could do on their own, a private exchange can offer new ways of reducing cost and improving value. Insurers will price their plans competitively and will offer plan options that avoid the “one size fits all” coverage that is the only option in many small firms.

Many private exchanges offer consumer support tools that may include plain-language questionnaires to help employees decide which plan best meets their needs, cost calculators, and physician finders.⁴⁹ Private exchanges may also offer supplementary insurance coverage, such as dental or vision insurance, and health savings accounts. Smaller employers can find private exchanges that reduce administrative hassle by integrating payroll, benefits, and other related functions.

The success of that approach depends on the patient’s willingness to travel for treatment, and some may not be willing to go long distances. That opens the door to negotiating discounts with local providers. According to Fitch Ratings, direct contracting between hospitals and employers will become more popular as health costs continue to rise.⁵⁰

Regulatory changes are necessary to create a health system capable of meeting the demands of consumers for high-quality care at reasonable prices. In January 2015, New York State took an important step in enacting a law that requires insurers to cover telehealth visits, paying for them at the same rate as in-person visits to a provider.⁵¹ The law covers a wide variety of communications between patient and provider, including telephones, remote patient monitoring devices, and video conferencing. Under the law, patients are responsible for the same out-of-pocket costs for an in-office visit as they are for a telehealth visit.

The new law has the potential to spur the adoption of more convenient, less expensive ways to provide health care. A recent study suggests that a telehealth visit saves about \$100, compared with the cost of an in-person visit to a doctor’s office, clinic, or emergency room.⁵² One report suggests that the global telemedicine market could nearly double in five years.⁵³

A barrier to the adoption of innovations in health care finance and delivery are requirements that prevent physicians and other providers from practicing unless they are licensed in New York State—even if they

are fully licensed in another state. Model legislation has been drafted by the Federation of State Medical Boards for an interstate compact to speed the licensing of doctors seeking to practice medicine in multiple states.⁵⁴ The compact would ease requirements for practicing across state lines, particularly for physicians relying on telemedicine.⁵⁵

New York's legislators should consider this "low-hanging fruit." The state would enter into an agreement only with another state that meets New York's high standards for medical training. Moreover, such agreements would not change the regulations for practicing medicine in brick-and-mortar locations.

Other regulations limit the adoption of more efficient methods of delivering health care. Scope-of-practice laws restrict the services that may be provided by nurse practitioners, physician assistants, and other skilled medical professionals. Such laws prevent health systems from employing nonphysician practitioners to provide care that they can provide safely and effectively, which raises costs and can delay the patient's treatment.

New York has recently expanded its scope-of-practice rules to allow nurse practitioners to practice independently, rather than under physician supervision.⁵⁶ The state should expand its review of such rules to identify additional opportunities to safely add flexibility in the way care is delivered.

CON laws limit whether hospitals and other medical facilities can enter new markets or expand their capacity. New York's Public Health and Health Planning Council recently recommended modest changes in the CON process.⁵⁷ The state should go further and repeal this anti-competitive law.

New York's legislature should resist the urge to impose tighter regulations on the health system under the guise of consumer protection. The Assembly may consider new rules that prevent major retail chains from offering primary care services through in-store clinics.⁵⁸ The state already bars publicly traded companies from owning medical facilities or employing physicians. Additional restrictions will limit access to convenient health services for millions of New Yorkers.

New York State can usher in a new era of creativity and competition in the health care market. Smarter regulation combined with smarter insurance will bring consumers better value, greater convenience, and more certainty that they will get the care they need when they need it.

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The Power of Knowledge: Arming Patients with Safety, Quality, and Pricing Data

Leah Binder, *Leapfrog Group*

Introduction

At times, health care can resemble a game of three-card monte. For decades, the pricing and delivery of health care services have been a mystery for all but a handful of economists and actuaries—and even *they* often have to guess. Experts, for example, are still trying to estimate how many people die annually from preventable medical errors in hospitals: the consensus now agrees that it's somewhere between 200,000 and 440,000.¹ In no other industry do experts allow for a margin of error representing hundreds of thousands of lives.

Vital information on the cost, safety, and quality of care are frequently obscured by the smoke and mirrors of arcane health care record keeping—record keeping established to efficiently bill third-party providers, not to effectively monitor whether patients get the best care for their dollars. Information may also be deliberately withheld by powerful incumbents, such as insurance plans, providers, and hospital chains, making it difficult for consumers to know where to find high-quality, affordable health care.

As a result, the people who most need such information—patients, employers, and other purchasers of health services—have little say on how their care is delivered, no insight into the result of that care, and only a vague understanding of how widely and dangerously the performance of providers varies. Even today, despite a nascent quality and transparency movement led by the National Quality Forum and others, such outcome measures are not fully standardized. Indeed, the current

situation is similar to comparing apples with oranges, and then with doughnuts and cupcakes—if you're fortunate enough to even secure the right data, a formidable challenge. For all but the most savvy, determined patients, finding the best doctor or hospital can be a deeply frustrating, often hopeless, endeavor.

New York, alas, is not a national leader in transparency, quality, or cost-effectiveness. In 2009 (the last year for which comprehensive data are available), New York's per-capita health care spending ranked seventh-highest in the country;² yet outcomes (the few for which data are available) are, at best, squarely in the middle of the pack. As noted in Chapter 1, a hospital a mile away from another can charge almost five times more for a patient with a heart-attack diagnosis—and, likely, with no difference in outcome.

Transparency is another big worry. Despite years of urging from many of New York's largest employers and health plans, the majority of the state's hospitals refuse to participate in the free Leapfrog Hospital Survey, the industry's gold standard. As a result, New Yorkers largely lack information on hospital quality provided voluntarily by hospitals in many other states.

Patient safety is a major embarrassment for New York State. This is particularly alarming, given the extent to which the U.S. relies on New York's academic medical centers to train the next generation of physicians, nurses, and other clinicians. Many of New York's leading academic medical centers consistently earn grades of C or worse on Leapfrog's Hospital Safety Score—which, given their limited transparency, is forced to (mostly) use Medicare data—far behind other states with major teaching-hospital centers like Massachusetts.³

Poor transparency means few incentives for providers to improve quality and reduce prices. For years, doctors and hospitals have passed along the cost of their inefficiencies to health plans, which, in turn, have passed the tab on to employers, and, finally, on to employees. In a 2013 *Journal of the American Medical Association (JAMA)* study, researchers culled the records of an unnamed hospital system to estimate the excess price that payers were charged when patients suffered (mostly preventable) surgical-site infections: \$39,000 for commercial payers, on average.⁴ *JAMA* researchers spent months calculating this figure because hospital systems are so opaque that providers themselves do not always know the sums involved.

Further, purchasers rarely have the leverage necessary to demand changes in the way data are tracked and presented. My nonprofit, the Leapfrog Group, was created by employers and other purchasers to help change that situation. Using the Hospital Safety Score, we assembled a team of researchers to develop a calculator⁵—free, customizable, and validated by Care Innovations, an Intel-GE partnership—with which purchasers can estimate hidden surcharges for hospital errors. Many employers, the calculator found, pay tens of millions of dollars—billions, in some cases—for excess costs related to harm and error (“hospital acquired conditions”).

This is especially true in New York, where patient safety lags. Unfortunately, the first time that employees typically realize that something is deeply wrong with the status quo is when they become victims of serious hospital errors or other substandard care, or receive a catastrophic bill for “balance payments” to out-of-network providers not covered by insurance. For such patients, who often are facing life-threatening situations, the three-card monte game of U.S. health care—where you do not know anything until it is too late—often turns into Russian roulette.

HDHPs

Happily, the rules of the game are changing. The “house,” moreover, could be on the verge of losing its biggest edge: the ability to control information about health care goods and services. While policy circles have largely focused on the Affordable Care Act (ACA), laws created under another president may be having as much, if not more, influence on the commercial marketplace today.

The number of high-deductible health plans (HDHPs), coupled with tax-protected health savings accounts, has grown dramatically, from virtually zero in 2006 to one in five workers nationally in 2013. Many employers are making this shift to avoid the ACA’s so-called Cadillac tax, scheduled for 2018. What is different about HDHPs is that employees pay virtually everything below their deductible, exposing themselves to actual prices.

Many debate the merits of HDHPs. Nevertheless, HDHPs are a fact of life for millions of families nationally, including in New York, where nearly 600,000 residents are enrolled in HSA-qualified HDHPs.⁶

With market forces arriving in health care, patients will invariably demand that policymakers tear down the barriers between them and the information they need to make informed decisions. Specifically, they will ask: What are we buying, and from whom? In the process, patients become shoppers.

I. The New Health Care Consumer: Informed and Empowered

While many debate the merits of high-deductible plans, few debate their implications: such plans incentivize consumers to compare prices for services they previously received at no direct cost (or for a low, predetermined co-pay).

Though they were given an extra tax advantage in the George W. Bush administration, HDHPs have recently grown fast, thanks partly to policies implemented by the Obama administration. The ACA, for instance, permits the sale of health plans with relatively high deductibles on state exchanges but restricts actuarial values, premium variation, and benefit design, ensuring that high deductibles are the norm.⁷ The ACA imposes the Cadillac tax, which is spurring employers to aggressively cut benefits.

Information: What's Available?

As millions of consumers enter the health care marketplace, an industry has arisen to satisfy their growing demand for information on pricing and quality, with firms like Optum, Clear Cost Health, Health QX, Health Advocate, WebMD, Vitals, and Castlight Health developing innovative tools to help consumers navigate the system.¹¹ A 2014 *JAMA*

Inside the Cadillac Tax

Starting in 2018, this ACA provision imposes a 40 percent excise tax on health benefits exceeding an annual limit of \$10,200 for individuals and \$27,500 for families—with such limits growing at the rate of inflation plus 1 percent in 2019–20, and at the rate of inflation thereafter.⁸

In 2018, one study estimates, only about 16 percent of health plans nationwide will be affected by the Cadillac tax; by 2028, the figure will rise to 75 percent.⁹ In New York, where public-sector employees typically enjoy highly generous plans (the average state employee is in a zero-deductible, 96 percent actuarial-value plan),¹⁰ the Cadillac tax's immediate impact will likely be higher than the nationwide average.

study found that as patients received access to, and used, a pricing website to research providers, claims costs fell by around 13 percent for lab tests and advanced imaging services.¹²

As noted, the Leapfrog Group collects data through its Leapfrog Hospital Survey, applying the leverage of hundreds of purchasers to persuade hospitals to participate. Leapfrog assigns letter grades for patient safety to more than 2,500 U.S. hospitals. Though few New York hospitals voluntarily participate in the survey, Leapfrog nevertheless uses data reported to the federal government to assign such hospitals letter grades.

The federal Centers for Medicare & Medicaid Services (CMS), as well as various states, including New York, now require hospitals that receive Medicare and Medicaid dollars to provide claims data and information on safety and quality. The Statewide Health Information Network for New York, or SHIN-NY (see Chapter 4), allows clinical patient information—such as electronic health records, images, and lab results—to be shared by doctors and hospitals, with the goal of reducing errors and unnecessary tests and improving care coordination. In New York, plans are afoot to create an all-payer database, where payers would submit information about insured individuals, their diagnoses, services received, and costs of care, among others, allowing for more apples-to-apples comparisons on cost and quality.

Information: What's Missing?

As more information becomes available, making it digestible will be no less vital. And as patients become empowered health care shoppers, they will demand not only price and quality information but easy access to their own health records—hardly the case now. Indeed, inaccessible records contribute to needless medical errors and higher costs.

At present, numerous barriers prevent a freer flow of important health information. A majority of hospitals, including specialty care and veterans-affairs facilities and major cancer institutions, are exempt from CMS disclosure rules. The CMS also limits the use of the data it collects. Further, direct comparisons between institutions and doctors are made difficult by the CMS's data adjustments to account for differences in patient risk. This impedes health researchers from examining raw health data: the CMS's risk-adjusted numbers may reveal how hospitals perform for the "average" patient but are less useful for,

say, an 80-year-old with aortic stenosis and diabetes requiring an aortic valve replacement. Here, creating physician-specific composite patient profiles for common procedures (including complication and mortality rates) would help. Likewise, making raw data available to commercial and nonprofit researchers would encourage innovators to find ways to repackage the data in useful ways for consumers. (See Chapter 4.)

In New York, a settlement¹³ between the state's attorney general and insurers limits the ability of health plans to reveal information on individual physicians' pricing practices and quality records. (Quality metrics for physicians also tend to be process-based, not outcome-based.) Some contracts between plans and providers limit transparency as well. Moreover, New York State's government faces limits on which procedures and types of pricing information can be released through its Statewide Planning and Research Cooperative System (SPARCS). In fact, there are so many barriers to transparency in New York that the state received an F in 2013 from the Catalyst for Payment Reform, which grades states on pricing transparency laws.¹⁴ (Several other states, true, received failing grades; see Chapter 2.)

Barriers formal and ad hoc, in other words, create big gaps in the information chain necessary for employers and employees to make more informed health care decisions. Such gaps include: accreditation reports; information on outcomes distinct from mortality and surgeon ratings (such as recuperation times for various procedures); disclosure of "never events" (hospital mishaps); and technical gaps (siloes of patient information that cannot be exchanged even with a patient's consent).

II. How Employers Are Addressing Information Gaps

The Great Recession and looming Cadillac tax have spurred many employers to experiment with new forms of insurance—such as narrow networks, tiered-benefit designs, reference pricing, medical tourism, and direct contracting—with the aim of offering employees better, more affordable, care while providing them with more information and say in how that care is accessed.

Employers face growing pressure to gather and disseminate useful data on patient outcomes. In their contracts with plans and providers, employers increasingly insist on language requiring disclosure on quality

and safety.¹⁵ Once employers obtain data, they are creating mechanisms, including online services and newsletters, to communicate the data more effectively to their employees.

Employers have even started banding together to use their combined leverage to pry open data vaults more broadly and to support government policies that would serve such ends. Leapfrog, for example, is backed by numerous employer groups interested in promoting transparency. Similarly, the Northeast Business Group on Health, an employer-led coalition based in New York, seeks to use the “collective influence of [its] members to drive healthcare value and reduce costs.”¹⁶

III. Turning Data into Action

Gathering data is but half the battle. Ensuring that it gets to everyone who needs it (i.e., all consumers of health care) and is readily understandable is the other half. Employers, plans, and providers have failed to communicate well with patient-consumers. Successful messaging techniques widely deployed by other industries have largely bypassed the health care industry. Limited transparency is partly to blame. So, too, is the admittedly complex nature of health care. Still, complexity is no excuse for poor transparency. After all, consumers routinely shop for complex, high-tech products: today’s iPhones have more computing power than did NASA’s Voyager 1 space probe when it was launched in 1977.¹⁷

Insufficient marketing savvy is also pervasive across the health care industry, though there are notable exceptions. Leapfrog, for instance, modeled its popular letter-grading system on New York City’s restaurant hygiene inspection system: an A grade on the window beckons customers while a C may deter them. Were similar grades widely advertised for the state’s hospitals, patients would, no doubt, derive little comfort from the fact that only 17 percent of New York’s hospitals earned an A on Leapfrog’s Hospital Safety Score—a mere 37th-best in the nation and far behind regional competitors such as Massachusetts (second) and New Jersey (ninth).¹⁸

Far more data, in other words, have to be benchmarked and boiled down into easy-to-compare metrics on provider performance. Take procedures: What is the provider’s “door to balloon” time for angioplasty during heart attacks? Take outcomes: How many of the provider’s diabetes cases result in amputations or other complications? We need to know the

answers to such questions, and we need the answers to be communicated as clearly and simply as possible. Likewise, health care consumers should be encouraged to consider price and quality information; to be inquisitive; and (especially among employers) to be willing to bargain on price.

There is also considerable opportunity for tech firms such as Amazon, Intel, and IBM to leverage their enormous computing power and analytical talent to make sense of the terabytes of unsifted health care–related data (while maintaining appropriate privacy safeguards). By making pricing and outcome data broadly available for mining, the disruption that has shaken up other sectors—to great effect—can finally extend to U.S. health care. And, not least, public and private employers must pressure the health care system to wholeheartedly embrace transparency. Doing so, employers must stress, is morally justified and in the system's commercial self-interest, for providers who fail to do so risk getting swept away by more open competitors.

Conclusion

U.S. health care is ripe for change. Pricing pressures and concerns about treatment outcomes are combining with employer initiatives and shifts in government policy to finally make the patient the central player in the country's vast health care marketplace.

New York State and New York City can help lead the way in this revolution by ensuring that every health benefits contract they sign, as well as every plan available on the state's health insurance exchange, includes safety information from a credible, neutral, third-party source, such as the Leapfrog Hospital Survey. The state legislature should also consider mandating disclosure of contract provisions limiting communication of cost and quality information: consumers should know when such information is intentionally shielded from them.

When health care consumers fully grasp their new, starring role—notably, their enhanced responsibility to determine the course and cost of their care—they will invariably clamor for the information needed to make informed decisions. This clamor, of course, won't become deafening overnight but will mount before long. And when the health care system is no longer rigged against consumers, the house will lose its edge, providers who offer patients the best value will flourish—and the patient will, at last, be king.

Endnotes

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Leveraging Technology: The New Lifeblood of Health Care

Mario Schlosser, *Oscar Health Insurance*

Introduction

“**B**lood Industry Shrinks as Transfusions Decline,” declared the headline of a *New York Times* article in 2014.¹ Over the last five years, transfusions were down in the U.S. by nearly one-third, the article reported, with blood banks nationwide trimming staff in the face of falling revenue.

One factor driving this change is less invasive techniques, such as laparoscopic surgery. And studies have shown that many transfusions are unnecessary, resulting in new guidelines about when to give blood transfusions. Computerization of medical records, the article continued, is transforming physician practices on transfusions, too. Many doctors now order transfusions from a computer screen; if their order conflicts with the tighter guidelines, the computer will issue an alert, and it monitors doctors who routinely exceed the guidelines.

Technology’s central role in this shift—not merely in surgical advances but in marshaling and communicating data that redefine and reinforce best practices—underscores one of modern medicine’s emerging realities: information is health care’s new lifeblood; and the data pipes that transmit it are health care’s new circulatory system.

The concept of data is now poised to remake health care just as it revolutionized manufacturing distribution systems across the retail industry and launched innovative companies like Google, Amazon, and Salesforce. Health care remains a decade or so behind the rest of the U.S. economy in utilizing analytics to improve performance and lower costs, but it is catching up fast. Practitioners must relentlessly focus on translating data into information that is relevant to consumers and patients, as the Affordable

Care Act (ACA) encourages public and private employers to shift more financial responsibility directly to consumers.²

In an age of algorithms and analytics, information on treatment, outcomes, and patient experiences can reveal patterns and lessons that are increasingly valuable to all major health care constituencies. With the insights drawn from such information, patients and consumers shopping with high-deductible health plans can seek the best providers at the lowest price; doctors and hospitals can become more efficient and effective in the treatment they give—and more competitive with their peers; and insurance plans, employers, and other payers can identify high-quality, low-cost providers and leave behind the rest by designing smarter provider networks. Though high-deductible plans may not be prudent for all patients with complex, chronic diseases, such patients have the most to gain from the information revolution because data on which providers and technologies deliver the best outcomes are currently lost, or are too arcane for all but health care experts to understand.

The company that I cofounded and run, Oscar Insurance Corporation, is a health insurer that uses data-driven insights to help members navigate health care—and to rewire the underlying health care system to better serve everyone. If our efforts and those of others are to be successful, the data on which we rely have to be accurate, relevant, properly collected, widely distributed, and consumer-friendly. When a critical mass of information eventually becomes publicly available, it will be possible to “hack” today’s health care system, producing sea changes in cost, quality, and effectiveness of care—delivered daily to consumers.

I. Where We Stand

Technology has opened the gates to more transparency in health care. But because of the many persistent barriers to collecting and disseminating medical data,³ what passes for information often remains just a best guess. When a genetic test, which promised 100 percent accuracy, revealed that our second baby would be born with a devastating condition, my wife and I were stunned. Yet we wisely sought a second opinion: an amniocentesis showed nothing worrisome; our second child was born gloriously normal.

How could a “100 percent” accurate test be so wrong? The initial clinical research into the test’s performance relied on a tiny sample of high-risk women, promising skewed results. This test represents fantastic scientific progress, likely leading to fewer false positives and false negatives when testing for genetic conditions during pregnancy; still, each year, data from hundreds of thousands of U.S. pregnancies are lost—unrecorded or unavailable to help optimize accuracy and, in cases such as ours, test performance—because the data are hidden in siloed electronic medical records systems, if not pen-and-paper clinical records.

Given the reach of today’s technology, we have the potential to collect and analyze all health care outcomes and all test results: What kind of information would we want to collect? Where would it be stored? How would it be available? What would we do with it? Who would use it? How would we best present it to consumers so that they can make the most of it?

II. What Data Do We Want?

We need information on quality and efficiency of care: metrics for inputs, outcomes, and costs. What is also essential, and typically overlooked or mismeasured, is the patient experience. Attempts to gauge patient satisfaction often start and end with doctors’ reviews. Studies reveal that these reviews do not always correlate well with clinical quality.⁴

Patient reviews are, of course, important. Indeed, patient-reported outcomes, when properly solicited, can often reveal more valuable data than those measured by providers. For instance, information on hospital readmissions for hip replacements is useful. Readmissions, however, affect only a small percentage of hip-replacement patients. What all patients experience following hip surgery is pain and extended rehabilitation: Did I walk pain-free six days after surgery? Ten days? Twenty days? Far more? Do I feel better?

Such information can now be gathered seamlessly by affordable “wearables,” produced by firms such as Fitbit and Misfit, that collect information on, for example, steps taken, sleep quality, and even mood. Properly collected and analyzed, these data can help answer vital questions: Which hospitals offer hip-transplant surgeries that return patients to full functioning sooner, at lower cost than competitors?

Such information can be equally useful to patients, providers (who can intervene if problems arise), and insurance payers.

Oscar now offers every member an Oscar-branded Misfit tracking device. Oscar's mobile app generates a member-specific, daily step-counting goal (usually 6,000–9,000 steps); each day that members exceed their goal, we pay a \$1 reward. Two months after launching the program, Oscar members had collected rewards for walking more than a billion steps.

This mix of qualitative/quantitative questioning and data collection—on a far more granular level than is now common—will produce information that is clearly relevant to all health care stakeholders. At Oscar, new enrollees are immediately asked about their health history; members can use Oscar as a one-stop shop for care information, drawing in relevant, obtainable outside records. For members who have struggled with certain medical conditions in the past, Oscar offers immediate medical attention from staff nurses.

For insurance companies, helping members in the moment—when they are experiencing a medical condition—should be a high priority. Yet an astonishing number fail to do so. In firms where member outreach is driven by monitoring claims, members' medical events are typically unknown for weeks, even months, until their claims are processed. (Internet retailer Amazon knew that my wife was pregnant months before my then-insurer knew.)

Real-time information is thus critical. Oscar became the first insurer in New York State to tap in to a real-time feed of emergency-room

All-Payer Databases

In some respects, APDs represent the holy grail of health care transparency. An APD collects claims paid by insurers—typically, private insurers, Medicaid, and Medicare payments—within a state. Such data are often made public (though sometimes on a restricted basis, with claims only for certain services made available). As of 2013, all but ten states have made progress in establishing APDs.⁵

Properly implemented, APDs can break down barriers impeding greater transparency in health care data. When clearly presented by commercial innovators, for example, such data can assist patients' decision making. And by aligning claims-based quality information with comprehensive clinical data sources, APDs offer enormous value to payers seeking high-quality, low-cost networks.

admissions for members. Our clinical team is duly alerted and phones members shortly thereafter. Some such conversations simply involve explaining benefits and next steps. Others offer greater impact.

Some ER admissions, for example, lead to follow-up surgeries scheduled without regard for patients' insurance status. In some 10 percent of ER admissions, Oscar observed members getting scheduled for follow-up surgeries with out-of-network physicians. To help members avoid the ensuing large out-of-network bills, Oscar began proposing comparable, high-quality, in-network surgeons.

Oscar also provides free, unlimited doctor televisits, through Teladoc, for individual commercial plans. One click on our mobile app or website pushes members' health histories to doctors, who call members back within ten minutes. Doctor can then diagnose and write prescriptions over the phone, sometimes after reviewing pictures attached electronically by members. Immediately after consultation, doctors' diagnoses and clinical notes are uploaded onto Oscar's systems and analyzed. When necessary, Oscar's clinical team reaches out to members requiring further help (with, say, a chronic condition). Real-time, comprehensive information—through lower-cost, more convenient telemedicine—makes this possible.

III. Where Would Data Be Stored?

Oscar does a good job of collecting health data on its own patients; but only by pooling as much information as possible, on as many patients as possible—all securely walled off from individual identities—will the concept of health data realize its full potential. New York has taken a positive first step in compiling health care data: the Statewide Health Information Network for New York (SHIN-NY) was created as a high-speed information highway for doctors and hospitals to access clinical information on patients.⁶

Sharing results leads to more informed decisions by providers, reducing errors, unnecessary tests, and increasing coordination. At present, however, SHIN-NY's data collection is voluntary and lacks cost information—thereby reducing some of the program's effectiveness—particularly, the ability to gauge efficiency. Ideally, cost and outcomes data should be collected, too. New York should therefore join other

states and take the next step in building its all-payer claims database (APD), requiring insurers to submit all claims related to patient treatment (including costs, outcomes, and pricing data) to a state agency.

Encouragingly, New York has passed legislation authorizing an all-payer database; but without reliable long-term funding, the project risks not materializing. Regardless, ensuring that data on outcomes, prices, and utilization are merged to develop evidence on comparative costs and effectiveness—of different treatments, providers, and adherence strategies—extends beyond SHIN-NY or an APD. Achieving this means having truly interoperable health records, owned and controlled by the patient and easily shared across providers, insurers, and health systems.

Interoperability would break down health systems' "walled gardens" that have trapped information on quality and outcomes within individual systems. Interoperability would incentivize competition among insurers, too, by easily allowing consumers to take their health care information with them when switching plans. (Given robust competition on state health insurance exchanges to become the benchmark plan for federal premium subsidies, many consumers will likely switch plans annually to keep premiums down.)

Interoperable health records would reduce wasteful duplication of tests and needless paperwork, improving continuity of care. Interoperable electronic health records (EHRs) would spur medical research by allowing data-analytics platforms to scan millions of records to identify disease patterns, predict and prevent adverse events, and advance the most effective treatments for specialized groups of patients. Indeed, as genomic data and targeted therapies for complex chronic ailments become routine, interoperable EHRs represent the future foundation of precision medicine.⁷

With New York's nearly 20 million residents and leading research hospitals and universities, a fluid health information ecosystem would offer the state a powerful base for economic growth by attracting health IT start-ups, pharmaceutical companies, and innovative providers. In such an ecosystem, sharing individual patients' treatment and health histories to facilitate better care would remain the core mandate, with appropriate privacy safeguards.

Patients would, for instance, decide if and how to allow de-identified health records to be used for research purposes, an approach similar

to Apple's Healthkit. Separate database views would distinguish various levels of privacy protection, depending on how the information was used and how potentially identifiable it was: genomic information would receive the highest level of protection; outcome and cost information would be much more accessible. Pooling information protocols could be established within the network as well, with access based on privacy risk and patient opt-in.

SHIN-NY's geographical reach should be extended beyond New York. By creating data-sharing agreements with platforms in other states to analyze data from out-of-state providers, SHIN-NY could leverage nascent telemedicine initiatives and allow patients and employers to compare costs and outcomes across multiple providers, in multiple states, to seek medical centers of excellence, regardless of location. This deep reservoir of data on clinical care, costs, and outcomes—eventually including genomic data—would be maintained in a computer system with an open application programming interface (API). An open API would permit researchers and stakeholders to mine data with predictive analytics and other tools—and emerge with valuable findings. (Given the recent intensification of health care–related cyberattacks,⁸ data security would, of course, be paramount.)

IV. What Would We Do with the Data?

U.S. health care requires better quality and lower cost. More actionable real-time information can drive both. When cost and quality metrics are derived from claims' histories, they confirm what studies have shown: there is little correlation between the cost and quality of American health care.⁹ In New York, more expensive providers (total cost of care, adjusted for input factors) display no differences in quality—they are neither better nor worse—from more efficient providers.

This is hardly surprising, for two reasons. The first is that the information required to incentivize providers—including physicians' quality metrics—into providing more value for the money is not publicly available.¹⁰ The second reason is that co-pays and nonexistent deductibles have long hidden the true cost of health care from patients.

Nevertheless, there are promising signs of change. Around 88 percent of individual plans on the federal exchanges have high deductibles

(defined as greater than \$1,300), requiring members to more closely monitor their health care spending.¹¹ In 2006, 4 percent of covered workers had deductibles of \$2,000 per year for individual coverage; in 2014, 34 percent of covered workers had deductibles of \$2,000 or more, according to the Kaiser Family Foundation.¹²

With publicly available information on pricing and quality, employers will be able to develop value-based insurance designs that encourage cost-effective therapies and to develop networks with efficient, effective providers. As employees grow comfortable staying within high-value networks, a virtuous cycle will ensue, with providers competing to deliver the best care at the best price. Such information will also help employers' initiatives, such as reference-based pricing and direct contracting.

The prospect of dramatically better care—and the many lives improved and saved as a result—is yet another tantalizing dividend. Best practices that were, in practice, best guesses will be affirmed or reformed once the wealth of data reveals statistically valid conclusions on outcomes; medications and tests will be dropped, or added, once enough data are sifted to reveal large-scale patterns tracking effectiveness. Innovators could, in turn, focus efforts on patients unresponsive to current therapies, further promoting the aforementioned virtuous cycle.

V. How to Secure Consumer Buy-In?

American patients have long been second-class citizens in their country's health care system. For New York's health care to turn the corner on costs and quality, patients need to be treated as valued consumers.

Yet without patient engagement and empowerment, the impact of information in this new circulatory system will, at best, be anemic. Patients, in other words, must be convinced that data will be used to improve their health care experience and outcomes, and they must buy in to recommendations inferred from the data, such as where, when, and how to seek care. Failure to secure patient buy-in will result in unhappy outcomes, such as the 1990s consumer revolt against managed care.¹³

Insurers offering narrow networks based solely, or mostly, on dollar considerations will, in the long run, be disappointed at their reception. If members do not understand why certain providers are covered and

others are not, members will naturally default to the broadest set of choices possible. Indeed, should narrow networks fail to prioritize quality—and make the marriage of better outcomes and lower costs clear to members—they, like HMOs before them, are doomed to fail.

High-quality networks are not, of course, the final reform. Health care is plagued by confusing, jargon-filled bills and explanations of benefits. Apple's success proves that complexity need not preclude simplicity for consumers.

At Oscar, our search engine understands everything from drug names to specialties to medical conditions (such as “I can't sleep”)—generating member-specific recommendations.

Any information that Oscar collects on members' health is fully available to members and presented intuitively in the form of an elegant timeline. In today's opaque health care system, however, Oscar's efforts to create straightforward communication tools were far from easy. For example, doctors fretted over Oscar's decision to allow patients to see their full clinical notes after televisit consultations—patients' freedom to scrutinize what doctors record might influence what doctors choose to record, some physicians worried—despite the fact that patients already enjoyed legal access to their medical records.¹⁴

Much previously unavailable information is now increasingly seeing the light of day. In 2013, New York State first published its State-wide Planning and Research Cooperative System (SPARCS) data set: a de-identified, risk-adjusted data set of all inpatient admissions, containing several years' worth of data. While payments (charges are included but do not necessarily correlate with costs) were stripped out, SPARCS does have provider information.

Publishing such data is vital. So, too, is building the technology required to make use of it. New York, for example, first published mortality rates, by physician, after coronary artery bypass graft surgery in 1990; 25 years later, few patients choose physicians based on such statistics, for the information is simply too difficult to discover.¹⁵

Oscar knows how important patient engagement is. In October 2014, Oscar announced that it would reward some members with \$20 for getting a flu shot over the next month; the rate of vaccinated members duly soared by 250 percent over that of members ineligible for the reward. High engagement rates are vital to closing the loop in the collection of

better health care information in ways directly actionable by consumers. Oscar uses a similar approach to simplify interactions with doctors.

The policy of most insurers for removing benign dermatologic lesions is to pay for the removal for medical reasons but not for cosmetic purposes. To enforce this rule, insurers require preauthorization—even though such procedures only cost a few hundred dollars and can be quickly done in the office. (Insurers might instead have replaced preauthorization with retroactive denials of claims displaying the wrong diagnosis codes, though this strategy can lead to errors as well.) Oscar's systems monitor claims in real time, singling out providers who perform frequent procedures for the wrong reasons. Oscar then tries to resolve the problem with just those providers, rather than indiscriminately punishing all dermatologists with complex preauthorization requirements.

Oscar has found that better information, technology, and service consistently benefit all members—whether “young invincibles” or those with chronic ailments. While televisit utilization, for instance, normally involves episodic issues (such as bronchitis and urinary tract infections), we have seen cases in which patients with chronic illnesses who were not receiving good care from primary-care physicians request care through televisits. In such cases, Oscar's in-house clinical team connects needy patients to in-person consultations with better primary-care doctors. “High-tech, high-touch” should be the goal.

VI. Spurring Continuous Innovation

To sustain New York's current positive momentum on transparency, technology, and information, employers and Albany should pursue the following initiatives:

1. Open SHIN-NY and APD for clinical and commercial research.

Though neither SHIN-NY nor APD is quite ready, regulators should plan to open up data to third parties, including for-profit companies developing consumer- and patient-focused products and services. A simple, predictable application process, with appropriate data integrity and privacy protections, should be available to all market entrants—commercial, nonprofit, and government.

Innovators should be allowed conditional access to the data through secure APIs. This kind of interoperability is precisely what researchers and consumer-facing companies require to interpret the information for patients and present it in actionable ways. A Mint.com-like platform would allow patients to access their medical records like their bank accounts—complete with visual analytics that help make sense of their health and health care spending over time. The platform could, in turn, be open to other apps that deliver fine-grained advice, from lifestyle changes to enrollment in clinical trials testing to the latest immunotherapies for treating metastatic cancer.

To ensure privacy, data access could be tiered, based on the risk of re-identifying the underlying information. A web-based research platform, for instance, could allow researchers to conduct statistical computations but not actually see the high-risk raw data (such as genomic data for rare diseases). Algorithms exist that could block a particular query from returning such identifiable results. Patients, as mentioned, should be queried at the point of care on whether they want their data to be used for health care research and whether they wish to be identified (through their health care provider, perhaps) when information relevant to their conditions (current or future) is uncovered—including clinical trials of new therapies.

2. Leverage New York's public exchange.

With statistics on quality and cost starting to make their way to the surface and 500,000 New Yorkers enrolled in coverage on the public exchange, Albany has a unique opportunity to nudge consumers in the right direction by integrating information on provider costs and quality directly onto its exchange.

SPARCS data can offer a wealth of information for consumers on specific providers. As people shop for insurance plans on the public exchange, some of this information could be presented simply. If, for example, a 30-year-old diabetic man residing in Albany shops for a plan, the exchange could use SPARCS data to show a composite quality score—based on outcome data for procedures common to 30-year-old Albany-based men—of physician networks for different health plans. The SPARCS data might even be used to predict health spending,

making it directly relevant for plan choice. Castlight and other firms could be contracted to pilot and scale up the information, as researchers find better ways to measure outcomes across the health care system.

3. Use New York's leverage to drive big-data efforts.

The key to turning data into useful information is to allow innovative companies to access the data from APD and SHIN-NY and make their results available to employers, patients, carriers, and providers. As noted, network-based insurance products that fail to take quality into account will fail the market test, as consumers err on the side of greater choice or higher-cost providers.

New York State should harness the wealth of information available through APD and SPARCS to incorporate new transparency and pricing tools into its public-employee benefit contracts—modeling gains from, among others, selective contracting, reference pricing, and centers of excellence.

Conclusion

With the Empire State's bevy of talented technologists, savvy investors, and increasingly motivated consumers, there is no limit to its ability to use data—wisely collected and shared—to transform its health care system.

Precisely what innovative applications and tools will emerge from these data are as unknown as the name of America's next Google or Amazon. What is certain is that data must be liberated to deliver better outcomes for patients. Done right, New York's health care system will ultimately resemble other competitive, consumer-focused, tech-savvy U.S. industries that deliver valuable innovation as a matter of course.

Endnotes

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Reform%20Center%20-%20Hospital%20networks%20national%20update%20%28June%202014%29_0.pdf. The Massachusetts experiment, discussed in Chapter 1, with tiered networks for state employees also saw significant uptake.

14. Providers are legally required to make records available to patients; often, bureaucratic and financial hurdles make it impractical for most people to access them.
15. Even so, publication of such mortality rates ushered in significant change. Hospitals took notice and put pressure on low-performing (typically low-volume) surgeons. From 1989 to 1992, 27 surgeons ceased practice in New York. In the last year in which they performed CABG surgery in New York, the 27 surgeons experienced a risk-adjusted mortality rate of 11.9 percent, nearly four times the state average. See Edward L. Hannan et al., "The New York State Cardiac Registries: History, Contributions, Limitations, and Lessons for Future Efforts to Assess and Publicly Report Healthcare Outcomes," *Journal of the American College of Cardiology* 59, no. 25 (2012): 2309–16.

Private Insurance Exchanges: How New York Employers and Policymakers Can Leverage New Reimbursement and Delivery Reforms

Robert Emmet Moffit, *Heritage Foundation*

Introduction

A health insurance exchange is a mechanism that enables employers and employees to pick and choose among different health insurance plans. Though such arrangements have existed for many years, in many different forms, the implementation of the Affordable Care Act (ACA) of 2010 has made the purchasing of federally approved health coverage through a public exchange a reality for millions of Americans.

While the ACA's public exchanges can be administered by the states or the federal government, they are not the nation's only health insurance exchanges; there are also private health insurance exchanges with far more flexibility to facilitate the defined-contribution financing of employer-sponsored coverage on a wide scale. The defined-contribution system, in which an employer allocates a specific annual payment amount to an employee's chosen health plan, facilitates consumer choice of coverage and also makes health plans more responsive to consumers' preferences and stimulates insurers' innovation in benefit and service design.

Private health insurance exchanges—market-based platforms for defined-contribution financing of employees' health plans—could emerge as a serious alternative to conventional employer

defined-benefit insurance or employee enrollment in the ACA's new public exchanges. There is a strong precedent for this sort of market transformation: the radical change in employer-sponsored retirement programs, beginning in the 1980s, when millions of Americans started moving from defined-benefit programs into defined-contribution pension plans, such as 401(k) plans.

Private exchanges allow employees to shop for plans offered by one or more insurers, depending upon whether the employer contracts with an exchange program offering single or multi-carrier coverage options. The employer can set parameters for the type of plans on offer, but the private exchange will provide more choice than is typical for the vast majority of employer-sponsored health insurance arrangements.

If private exchanges prove effective in controlling health care costs while still providing employees with desirable coverage, such exchanges could strengthen employer-based coverage at a time when it is under great financial stress. They could also accelerate the transition to consumer-directed health insurance arrangements, such as health savings accounts, and spur evolution toward a more cost- and quality-conscious health system, as price-sensitive employees seek out insurers and providers in a transparent, highly competitive environment. Accenture, a management consulting firm, projects more enrollees in private exchanges (40 million) than in public exchanges (31 million) by 2018.¹

Today, at least 6 million people are enrolled in private exchanges across the country, up from around 3 million in 2014.² But the combination of rising costs and the ACA's new federal regulations and taxes is helping stimulate interest among employers that want to retain employer-sponsored coverage, secure greater flexibility in financing, and offer more options in benefit design.

In the Empire State, these changes are well under way. Xerox, one of the top ten employers in New York's Finger Lakes region, has moved its employees onto private exchanges. Time Warner (with corporate headquarters in New York City), as well as General Electric and IBM (among New York's largest employers), has already moved tens of thousands of retirees onto private exchanges.³ National firms with sizable employee and retiree populations in the state, such as AT&T, Caterpillar, Darden Restaurants, General Dynamics, Petco, Sears, and Walgreens, have enrolled, or are enrolling, employees or retirees in private exchanges.⁴

With the imposition of the ACA's 40 percent excise tax on high-value health plans (the "Cadillac tax") beginning in 2018, more large employers are planning ways to avoid the tax, such as by imposing more cost-sharing, reducing benefits, or restructuring their health insurance arrangements.⁵ There are many different ways to redesign health insurance that can help employers stay below the Cadillac tax threshold, including narrowing provider networks, adding more cost-sharing, and increasing care coordination or case-management programs for chronic illnesses that may slow cost growth. Moving to defined-contribution financing and enrolling employees in a private exchange could be another attractive option for numerous employers that could incorporate many of these elements without locking employees into a one-size-fits-all plan design. Indeed, this could prove far more attractive than off-loading workers onto public exchanges, particularly for workers who do not qualify for federal insurance subsidies because their incomes are too high.

Under existing Internal Revenue Service (IRS) rules, employers cannot make pretax defined contributions for individual health insurance on the public exchanges. But as long as the contribution is tied to group health coverage, it remains tax-free. This makes private exchanges particularly attractive for self-insured employers exempt from state insurance regulations under the Employee Retirement Income Security Act of 1974 (ERISA).⁶ Nevertheless, some of the largest private exchanges—Mercer Marketplace, for instance, serves 247 companies and more than a million people—offer fully funded plans, too.⁷

For many employers, competing private exchanges could serve as strong platforms for expanded employee choice and patient satisfaction, greater cost control, better health outcomes, and more competitive, transparent pricing of medical goods and services.⁸ Private exchanges can also become vehicles for new health-benefit designs, more rapid advances in health care delivery and payment reforms, and a superior method of securing value for health care dollars among employers and employees alike.

I. The Coming Revolution in Employer-Sponsored Coverage

Many trends are driving the adoption—or, at least, serious consideration—of private health insurance exchanges by a growing number of private employers.

Rising Costs and the Lure of Federal Subsidies

Employers of all sizes have been struggling with health care costs for many years and have been cutting back on plan coverage in one way or another, such as limiting networks or increasing deductibles. But the ACA's higher taxes and regulatory costs are heightening employers' anxiety, stimulating them to search for innovative ways to provide coverage and encouraging them to rethink their role in providing health insurance. While the Obama administration and its congressional allies have championed the ACA as the vehicle to reduce health care costs for businesses and families, the national health law's insurance regulations, as well as its new taxes on drugs and health insurance, will be passed on to employers and employees in the form of higher premiums.⁹

Numerous studies have revealed that business leaders, in New York and elsewhere, do not expect the ACA to reduce health cost pressures on employers. The Federal Reserve Bank of New York, for example, conducted surveys of business leaders and manufacturers and found that neither group expected the ACA to reduce health benefit costs.¹⁰ In response to the law's anticipated costly impact, 60.5 percent of manufacturers and 54 percent of business leaders responded that they will make "modifications" to their health plans.¹¹ Such changes will include making employees pay higher deductibles, co-payments, or premiums, as well as reducing employee coverage, the range of services covered, and the size of medical provider networks.¹²

Rhetoric aside, the federal government, with its muscular system of mandates, penalties, and insurance subsidies, is introducing powerful new economic incentives for employers to consider limiting their exposure to health insurance costs—if not exiting the health insurance business entirely. Consider Standard and Poor's 500 companies. Global Markets Intelligence estimates that a corporate shift of health care costs to taxpayers, as well as greater cost-sharing among employees, could save these companies approximately \$700 billion by 2025.¹³ For American companies with 50 or more workers, the business savings secured by such a cost shift could amount to as much as \$3.25 trillion by 2025.¹⁴ About 40 percent of American workers will be eligible for federal premium subsidies on the public exchanges.¹⁵ Given this, the financial temptation among financially stressed employers to end providing insurance coverage for a large fraction of their employees may eventually become irresistible.

Whatever the intentions of its congressional sponsors, the ACA is giving employers powerful financial incentives to rethink how they have traditionally provided employer-based health insurance coverage. Indeed, it is driving employers to seek new ways of offering valuable coverage to employees, while also encouraging them to better manage rising health care costs. If employers' efforts fail and the result is an influx of millions of employees flooding the public exchanges, taxpayers will bear a far bigger burden than federal government actuaries currently project.

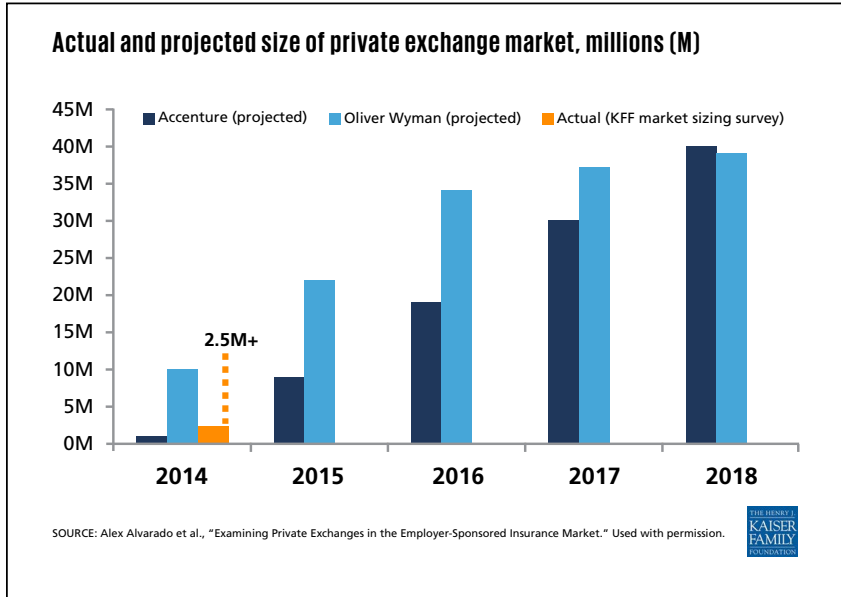
The Cadillac Tax and the Defined-Contribution Advantage

“Over the long run,” says Global Markets Intelligence, “the ACA may eventually come to be historically recognized as the starting point of the reconstruction of the health care industry and a catalyst for how companies provide health care insurance for their employees.”¹⁶ As noted, companies wishing to retain a role in the provision of health insurance are likely to pursue a number of strategies, including restructuring their health insurance benefits and accelerating the corporate adoption of high-deductible, consumer-directed health plans, such as health savings accounts and health reimbursement accounts.

The ACA's Cadillac tax—the 40 percent excise tax on high-value health plans that operates as a de facto cap on the tax deduction for employer-provided insurance beginning in 2018—will play a major role in companies rethinking their health-benefit designs. The Congressional Budget Office (CBO) expects the tax to generate an estimated \$120 billion in revenues by 2024.¹⁷ According to a 2014 Towers Watson survey, 62 percent of large and midsize companies say that the tax will “strongly influence” their health care decisions over the next two years.¹⁸ The Hoover Institution's Lanhee Chen predicts: “Employers will probably respond to this tax by paring back benefits to avoid it, or terminating coverage entirely and instead offering a defined contribution toward an employee's individual health insurance purchase.”¹⁹

Private exchanges are the most promising vehicles to effect that transition. For example, a Kaiser Family Foundation survey found that among the largest employers (with 5,000 or more workers), 25 percent said that they were “considering” a defined contribution, and 20 percent said that they were “considering” offering benefits through a private exchange.²⁰

A large-scale employer transition to defined contribution for health coverage among active employees would amount to a revolutionary change in American health care financing. A rapid expansion of private health insurance exchanges would logically and quickly accompany that change (see graph, below).²¹



Source: Alex Alvarado et al., "Examining Private Exchanges in the Employer-Sponsored Insurance Market." Used with permission.

II. Private Exchanges Today

Numerous companies—including Darden Restaurants, Sears, and Walgreens—already use private exchanges: about 2 percent of large companies currently use them for active employees, and 4 percent use them for retirees, according to the Kaiser Family Foundation.²²

In New York, major benefit firms such as Aon Hewitt, Liazon, and Mercer are sponsoring impressive private exchange options. In western New York, for example, employers working with Liazon offer eight health plans, ranging from high cost (\$585 monthly premium) to low cost (\$227 monthly premium).²³ Liazon also runs an exchange program, "NuOptions," that serves New York employers, providing employees

with an interactive guide to assist them in selecting health plans, including videos, calculators, and access to licensed benefit counselors.²⁴ Similarly, Mercer has established the “Mercer Marketplace” for participating employers and tens of thousands of their employees.²⁵ In 2014, Mercer announced that firms that enrolled in their exchange option saved \$800 per worker, on average, with almost one-third of such savings going directly to employees.²⁶

Perhaps the most prominent example of a well-functioning employer-sponsored health insurance exchange is the Federal Employees Health Benefits Program (FEHBP), a multi-carrier program serving more than 8 million federal workers, retirees, and their families. In contrast to most large private employers, the federal government is not self-insured. Just like fully insured private-sector employers, the federal government contracts with health plans in the FEHBP that bear the risk and responsibility for paying all claims.

Created in 1960, the FEHBP is the world’s largest group health insurance program, with hundreds of competing private health plans, including various national and local plans. The federal government, as an employer, makes a market-based defined contribution to a wide variety of health plans chosen by federal workers and retirees.²⁷ Under the current formula, the defined contribution to private health plans is equal to 72 percent of the average weighted premium of competing national plans and annually capped at a specific dollar amount.²⁸ If federal workers wish to purchase a plan that costs more than the government contribution, they may do so but are responsible for paying the full amount above the government’s contribution.

The FEHBP has been very popular and successful in delivering quality coverage at competitive premiums. The program has registered superior enrollee satisfaction and has historically outperformed conventional private insurance in controlling costs. During the 1980s, the Congressional Research Service (CRS) found that while private health insurance premiums rose by 14 percent, FEHBP premiums rose by 12 percent; adjusting for the program’s significant benefit expansions between 1983 and 2003, including prescription drugs, a 2003 Joint Economic Committee analysis found that the FEHBP even outperformed the price-controlled Medicare program.²⁹

Private Exchanges for Small Businesses

New York's 400,000 small businesses account for almost two-thirds of the state's employment.³⁰ For firms with 25 or fewer workers, the ACA's small-business tax credit—which, in 2014, provided a tax break for up to 50 percent of premium costs—has had only limited appeal to date, and it phases out in 2016.

Private exchanges can be attractive to many of these small businesses. While the ACA's Small Business Health Option's Program (SHOP) is an obvious alternative for such firms, it, too, has had a troubled implementation at the national level. As of June 1, 2014, only 76,000 individuals had enrolled in the SHOP exchanges nationwide, according to the Government Accountability Office (GAO), of which 10,023 were New York residents.³¹ Small-business owners are largely unimpressed with the "small menu" of health insurance offerings on these exchanges and find the available federal tax credits too complex administratively and too "limited" in their impact.³² That is why private exchanges could prove more attractive to these firms. Indeed, reports the GAO: "According to some agent and broker representatives, private exchanges may appeal to employers because, in some cases, they offer employee choice—a key value proposition of the SHOP that has not yet been implemented in all states—without many of the requirements associated with SHOP."³³

In New York, private exchanges are already taking root among small businesses. New York's HealthPass, established in 1999, was an early entrant in the private exchange business. Today, it serves 3,300 small employers and 30,000 employees and their families. In 2012, the firm conducted a survey of New York small employers: 52 percent, the survey found, would prefer a private exchange, while only 28 percent preferred a public exchange.³⁴

A self-insured private exchange option, exempt from the ACA's essential benefit requirements, would offer even greater flexibility for small firms. The growth of exchanges for large self-insured firms may increasingly encourage small employers to self-insure and join with larger corporations in the more flexible, ever larger private exchanges. *Health Affairs* notes: "Arguably, small and mid-sized employers could benefit even more than large employers from exchanges, because large employers already enjoy a competitive insurance market, have the resources to

manage health care costs, and experience economies of scale—advantages that are unavailable to small and midsized companies.”³⁵

Stanford’s Alain Enthoven observes: “One important thing about the private exchanges is that they can be in the economic best interest of all participants. Private corporate exchanges are market-driven. They can display the innovation and flexibility of the private sector, rather than the complex, politically negotiated, legislated treaties that constrain the public sector exchanges. The private exchanges can hire the expertise they need when they need it, and are not bound by the complex bureaucratic public sector personnel and procurement regulations.”³⁶

It is likely that Americans’ growing familiarity with the public exchange concept, realized through the ACA, will make them more comfortable with the private exchange concept. In fact, a robust growth of private exchanges—characterized by a major expansion of their service areas and the inclusion of ever more employers—would introduce a measure of portability into employer-based health insurance that does not exist today, allowing individuals and their families to seamlessly transfer their personally chosen coverage from job to job among companies participating in the exchanges, allowing them to change insurance policies as their jobs and financial circumstances change. Under these circumstances, patients and consumers will value the portability of insurance even more highly, and plans will have an additional incentive to encourage customer satisfaction to reduce “churn” across exchange markets.

III. How Private Exchanges Offer New Opportunities for Employers and Employees

A private health insurance exchange must, of course, abide by the statutory requirements of current law. This includes the ACA, ERISA, Consolidated Omnibus Budget Reconciliation Act (COBRA), Health Insurance Portability and Accountability Act (HIPAA), and Internal Revenue Code.

While current federal law creates a formidable array of statutory obstacles regarding what employers can do, it nonetheless leaves room for employers to navigate the available terrain for independent action

and create or participate in private health insurance exchanges. Time will tell whether the latter option proves successful.

The Cadillac tax caps the tax deduction available for employer-based coverage but does not eliminate it. There is an enormous gap between the generous tax benefits for employment-sponsored group health insurance—the tax deduction for employers and tax exclusion for employees—compared with health insurance purchased in the individual market. This radical difference in the federal tax treatment of health insurance means that any person buying individual health coverage, as opposed to receiving coverage under an employer plan, could pay 20 to 50 percent more for health insurance.³⁷

While the employer “subsidy” for an employer-sponsored defined-benefit plan is tax-free, *no* employer-defined contribution on behalf of an individual to a health plan in the individual market, either on or off a health insurance exchange, is tax-free. Under IRS rules, employers that reimburse employees for individual market plans, on or off the exchanges, are subject to tax penalties of \$100 per day, or \$36,500 annually, per employee.³⁸ For tax policy purposes, the crucial distinction governing employers’ use of defined contributions is whether the plan is a group or an individual plan. An employer’s defined contribution within the employment-based group insurance that satisfies the ACA’s requirements is legally permissible—as is an employer’s contribution to a health reimbursement account (HRA) or a group plan for retired former employees.

The defined-contribution option may provide a sweet spot for companies to continue offering insurance while reducing their exposure to the Cadillac tax *and* avoiding the penalties that come with dropping coverage entirely. The CBO estimates that the ACA’s employer-mandate tax penalty will generate ten-year revenues of \$167 billion by 2024.³⁹ These tax penalties, \$2,000–\$3,000 annually for each employee without approved health coverage, become fully effective in 2016. Of course, these penalties do not apply to employers retaining insurance coverage under the law’s mandatory minimum coverage requirements for individuals and families. The gap between the relatively small penalties imposed by the employer mandate and the regular cost of employer-sponsored health insurance is huge. Single employer-sponsored coverage in 2014 averaged \$6,025 annually, for example, while average annual family premiums topped \$16,834.⁴⁰

Nonetheless, the Towers Watson survey of large and midsize employers shows little or no interest among employers in sending employees onto the public exchanges: 77 percent “lack confidence” in the public exchanges.⁴¹ While raw economic incentives for dumping employees out of existing coverage may be powerful, employers realize that such a decision will incur other costs, some tangible and others not, such as the lowering of staff morale or making the firm less competitive in labor markets.

The final calculus for employers is likely to be complex. For 2015, low-income workers, especially those whose annual income ranges between 100 and 250 percent of the federal poverty level (FPL; between \$11,770 and \$29,425 for a single person), would be eligible for generous government subsidies for both their insurance premiums and out-of-pocket costs. If they would find the loss of their employment-sponsored coverage acceptable and find the public exchange plans more to their liking, they could certainly become winners in such a transition. Firms with many low-wage workers are likely to find that dropping their company coverage for such workers is a win-win proposition.

For workers whose income is above 250 percent of the FPL (\$29,425 for an individual; \$60,625 for a family of four), premium subsidies for insurance coverage on the public exchanges would be less generous, and the law’s cost-sharing subsidies would disappear entirely.

For workers with an annual income in excess of 400 percent of FPL (\$47,080 for an individual; \$97,000 for a family of four), there would be no premium subsidies on the public exchanges. After losing the employer’s coverage and generous tax-free subsidies, these workers and their families would pay substantially more than what they would have paid under employment-based coverage. In 2016, the CBO estimates that a family of four with an annual income of, say, \$124,000 would pay roughly \$6,300 more annually to receive coverage on a public exchange (assuming that they lost their tax-free employer subsidy).⁴²

Private health insurance exchanges would enable employers to maintain their group insurance coverage and generous benefits, while allowing employees a broader range of personal choice among private health plans. Because employers would sponsor and finance the private exchange, it would remain group coverage within the terms of existing federal law, thus serving as an “employer’s plan” for federal tax-code

purposes. Defined contributions made on behalf of workers enrolled in the group plans within the private exchange would therefore be tax-free, just as they would be under conventional employer-based, defined-benefit health insurance arrangements.

The Business Case for Defined Contribution

Another advantage of a defined contribution through a private exchange is that it allows employers the opportunity to focus more directly on their core mission: the business of the firm. Employers can focus on developing and marketing products, and developing, training, and deploying the talent of employees, rather than negotiating and micro-managing employee health benefits (which does not directly add value to the enterprise).

Private exchanges could also open a better window onto the cost and effectiveness of employers' health care financing for employees and its impact on the behavior of medical professionals delivering care in competitive environments. Exchanges can leverage analytic platforms that allow employers and employees to compare data on plan price and performance, giving plans and providers alike powerful incentives to improve their effectiveness in treating, curing, and managing disease to seize market share. Private exchanges could thus serve as conduits for "Big Data" analysis of health plans and provider networks that foster innovative delivery reforms faster, and with greater cumulative resources, than single employers could achieve on their own. Health plans that excel in this environment would be rewarded with greater market share if they pioneer successful strategies that improve the health outcomes of employees and deliver better value, per-dollar spent, than competitors.

A private exchange can engage consumers more directly and rapidly by bundling much of what is already occurring in much of the conventional employer-based system, even though patient choice over benefit options and the flow of dollars would still be guided through the employer—retaining the employer's role as trusted concierge for employees.

Most large firms—such as Boeing, Dow, Eli Lilly, Honeywell, JPMorgan Chase, and Marriott—are providing employees with a variety of health-promotion programs, including health-risk assessments, metabolic screening, smoking cessation, and weight-loss initiatives.

For example, 56 percent of large employers offer employees biometric screening to assess risk and secure better health outcomes.⁴³ Johnson & Johnson reports a return on investment averaging between \$1.88 and \$3.92 for every dollar invested in health-promotion programs.⁴⁴ JPMorgan Chase rewards workers with a \$200 deposit in their medical savings accounts if they complete a biometric screening assessment but increases their insurance premiums if they do not.⁴⁵ Chronic disease-management programs could easily be integrated into competitive private health insurance exchanges, with additional incentives, including higher plan contributions, premium discounts, or reduced out-of-pocket payments for employees wishing to enroll.

Likewise, private health insurance exchanges would be a good testing ground for private, consumer-driven accountable care organizations (ACOs). ACOs are based on the concept of gain-sharing among groups of medical professionals for taking on the risk for a population, delivering high-quality care for lower cost, and doing so in accordance with best medical practice standards or evidenced-based medicine. In principle, given the promised benefits, this option should be attractive to workers and their families. It is based on teamwork among physicians, nurses, and other medical professionals. It encourages care coordination and case and disease management. Medica, a private exchange sponsor, offers employers and employees four ACO networks (ranging from 400 to 2,500 providers) in addition to its regular and ancillary health plan offerings.⁴⁶

Unlike the highly regulated ACOs in the Medicare program, where patients are “assigned” to the organization, private-sector ACOs exercise greater flexibility in their business operations and goals and do so under the added competitive pressures of real consumer and patient choice in a fully transparent environment. With the benefit of a level playing field for competition, private-sector ACOs would have the chance to prove themselves as desirable and effective options for patients.

Large employers are already promoting various other strategies to enhance employees’ care, including: the use of telemedicine; insistence on greater price transparency for medical services; use of financial incentives to achieve better health outcomes; and use of consumer-directed health plans, such as HSAs and HRAs. Preliminary data show that workers enrolled in private exchanges are enrolling

in consumer-directed health plans at a much faster rate than those enrolled in traditional employment-sponsored coverage.⁴⁷ As private exchanges become more prevalent, it seems likely that consumer-directed, high-deductible plans will also flourish.

Regarding the potential of private exchanges to control costs, Aon Hewitt comments: "The most compelling feature of the Exchange lies in creating a competitive marketplace. Competition between insurers for each consumer's business will mitigate long-term cost increases."⁴⁸ The evidence, albeit preliminary, is promising. Bloom Health, established in 2009, administers an exchange program for approximately 250 employers in 24 states. In 2013, Bloom's per-employee insurance spending was \$8,390 through its exchange program, compared with the \$10,789-per-employee nationwide average.⁴⁹ In 2014, according to Mercer, more employees were attracted to lower-cost plans; when combined with care management and prescription programs in exchange plans, employers secured cost savings of 15 percent.⁵⁰ Mercer also reported average savings of 10 percent on life and disability benefits through its exchange program.⁵¹ According to an Aon Hewitt survey, the vast majority of employers (86 percent) considering a move toward a private exchange rank cost reduction as their number-one reason.⁵²

In a new competitive environment, health plans trying to attract subscribers will put a premium on showing how they can deliver quality or increase patient satisfaction. This could be done through adopting new benefit designs or unique, cost-effective care-delivery arrangements, such as direct patient payment to medical professionals.⁵³

In contributing to innovative plans and providers in private exchanges, employers can insist that carriers offer their employees plans that provide clear, accessible data on a medical professional's performance in delivering quality care, as well as full transparency on medical pricing. More workers and their families, enjoying the benefits of personal savings through HSAs or lower premiums, will demand such information and act on it.

Private exchanges can secure predictability for employers in their financing of job-based medical insurance. With a defined contribution, the employer can make a clear management decision in the current and future reallocation of total employee compensation, rationally readjusting payment of wages and the financing of various

employee benefits, while exercising more direct control over the company's health care spending.⁵⁴

Finally, private exchanges can secure administrative savings. Many of the traditional functions of the firms' human-resources departments—such as negotiating with insurers over terms and conditions of coverage, enrolling employees in the selected health plans, payroll deductions and premium allocations, and related time-consuming paperwork—can be transferred to the private exchange. In this transfer, there will be an increasing corporate demand for more sophisticated information technologies to process data. Accenture notes: “These are not new concepts for seasoned administrators, but leading exchanges will build automation to help reduce manual costs and minimize errors. Furthermore, these rules and processes should seamlessly integrate into an intuitive front-end consumer shopping experience. Exchanges that do not streamline and automate enrollment and eligibility processing for their employer partners will likely fail to deliver on a core promise of reduced administrative burden.”⁵⁵

Employee Advantages

Employees, like employers, value stability. As a general rule, enrollment in private health insurance exchanges would be far less disruptive for workers than being summarily dumped out of their existing employment-based health coverage and left with no alternative but a public exchange. The worker's encounter with the private exchange would take place through an online portal, armed with decision-support tools and the opportunity to choose among a variety of plan options (likely those quite familiar to the worker). With enrollment in a private exchange, *Health Affairs* suggests that “the switch may be invisible to employees, who may only notice that they are signing up for insurance through a different interface, using a different benefits manager.”⁵⁶ Preliminary data show that plan switching in private exchanges declines significantly in the second year of operation.⁵⁷

Whether workers would be full-time, part-time, or contract employees, a private exchange would enable them to get and keep their job-based coverage, with the added benefit of being able to choose the specific kind of health plan that meets their personal needs. Generally, employees desire choice and flexibility in their health insurance options,

the kind best achieved through a defined-contribution system. Accenture found that workers enrolled in private exchanges are willing to make trade-offs in their health insurance plans, including paying higher deductibles, enrolling in wellness programs, and greater cost-sharing in return for lower monthly premiums.⁵⁸

As noted, workers enrolling in a private exchange, with a large service area that attracted a large, diverse number of participating employers in their state of residence, would have an expanded (though still limited) portability of health insurance. Within the exchange, they would be able to take their coverage to new employers in the same exchange and maintain continuity of coverage and care without losing generous federal tax benefits for health insurance. A long-term relationship between insurer and subscriber gives the insurer a powerful incentive to invest in the wellness of the worker, reduce preventable illnesses, and help the worker and his family maintain good health.

IV. What Employers Can Accomplish Through a Private Exchange

One of President Obama's stated goals in enacting the ACA was to increase the competitiveness of the nation's health insurance markets. The Kaiser Family Foundation notes: "The long-term success of the exchanges and other ACA provisions governing market rules will be measured in part by how well they facilitate market competition, providing consumers with a diversity of choices and hopefully lower prices for insurance than would have otherwise been the case."⁵⁹

Since the enactment of the ACA, New York State has experienced a further increase in individual market plan participation and a decrease in market concentration. As of March 2014, 16 companies were offering health plans on New York's exchange; only seven of these companies held market shares greater than 5 percent.⁶⁰ Pointing to the broadening of the New York market, the Kaiser Family Foundation notes that WellPoint, which offers the Empire Blue Cross and Blue Shield plan, controlled 28 percent of the state's individual market in 2012; but as of December 30, 2013, WellPoint controlled just 18 percent, with smaller health insurers taking up a larger share of the market.⁶¹

In this respect, New York is unusual. The Empire State's success in expanding and de-concentrating its individual market stands in sharp

contrast to the general pattern of market concentration and the weakness of competition evident in most other states, before and after the ACA's enactment. From 2013 to 2014, there was a 29 percent reduction nationwide in health plan competition in the individual market, as measured by plan participation.⁶²

By creating or joining a private exchange, New York employers can reap the benefits of an even more intensely competitive market through private ACOs or other direct contracting arrangements. Though taxpayer premium subsidies are confined to public exchanges, the U.S. Department of Health and Human Services (HHS) ruled in 2012 that federally “qualified health plans”—those exclusively eligible to offer benefits on public exchanges—can also offer coverage in private exchanges.⁶³ This further broadens the employer's range of options. By participating in a “multi-carrier” private exchange, employers can tap in to New York's multiplicity of insurance carriers. In short, New York employers should avoid the “single carrier” exchange, which simply replicates the noncompetitive structure of health insurance markets in many other states, such as Alabama, Mississippi, and Rhode Island.

In maximizing consumer choice and market competition by attracting multiple carriers as well as multiple plans and options, a private exchange would thus function like a large, single, consumer-based market. If properly designed, carriers and plans would freely enter and exit the market, new product lines and innovation in benefit designs and services would be the norm, and new coverage options would emerge in response to the dynamics of consumer demand. In such a market, workers and their families should expect more than a simple rerun of past employer practices; more than just some new variations on old paternalistic themes; and more than just some new formats for older health insurance models, such as traditional indemnity plans and health maintenance organizations.

Robust competition among carriers would enable workers and their families to secure real value for their health care dollars. Free-market transactions would improve patient satisfaction, control costs, and drive innovation and productivity in health care delivery. Says Enthoven: “Once individual choice is introduced, carriers can innovate with plans that please some, but not necessarily all employees, plans that could not be offered in the one-size-fits-all model. Individual choice

facilitates more selective networks. Employees' choices reflect their personal valuations of alternative health plans. Employees are more likely to be satisfied with a plan they have chosen for themselves."⁶⁴

V. Removing Barriers to Private Exchange Growth

Employers can maximize economic efficiency without waiting for state or federal policymakers to act, and thus, to a limited extent, bypass political inertia and regulatory sclerosis. Private exchanges can foster health care competition and innovation, serve as needed conduits for cost and quality transparency, and encourage more rational consumer behavior in health care markets. State policymakers can facilitate the growth of private health insurance by, among others, pursuing the following three steps.

1. Rethink traditional public benefit designs and performance.

The consequences of the Cadillac tax for New York State, New York City, and municipalities are poorly understood by the public and even by rank-and-file union members. Barbara Van Epps, deputy director of the New York State Conference of Mayors and Municipal Officers, estimates that at least two-thirds of her members' employees could be affected by the tax.⁶⁵ New York City mayor Bill de Blasio has already negotiated agreements with the Uniformed Superior Officers Coalition for health savings (though the exact mechanisms for such savings remain largely unspecified). The city argues that if unions cannot deliver the savings unilaterally, both parties will be brought into binding arbitration to establish savings mechanisms (though the final outcome of any arbitration process is, likewise, uncertain). While a step in the right direction—especially in its provisions for shared savings for taxpayers and unions from cost reductions—New York's unique collective bargaining environment (under the Taylor law, unions can walk away from contract negotiations leaving the previous contract provisions in force) has many municipalities frustrated by their lack of leverage on pension and benefit contract negotiations.

The reality of expansive, expensive health benefits for current employees and retirees is that it leaves unions and employers battling over a

shrinking pie. This, of course, makes it increasingly difficult to allocate resources to future wage increases or investments in the state's critical infrastructure. Highlighting the impact of the Cadillac tax on New York State and municipalities—given current contract terms—is a critical step toward developing realistic strategies for slowing health inflation to a more sustainable rate, for taxpayers as well as union members. New York's state legislature should thus require clear public reporting of health insurance contract terms for state and municipal employees (including retirees) and should also conduct an independent, statewide audit on the cost of the Cadillac tax for taxpayers and employees from a representative sample of state and local employers.

The audit would project the full cost of the Cadillac tax as well as assist policymakers in finding ways to “right-size” health benefits for public employees, with specific ideas rather than unspecified savings. Using competitive private exchanges, financed through a defined contribution, is the approach that best comports with New York's overall goal of delivering high-value health care for all residents—while incorporating the most flexibility in providing innovative cost and transparency tools with employee choice.

2. Enroll state and local employees and retirees in private exchanges.

New York can help jump-start emerging private exchanges by enrolling state employees (current and retired) in such exchanges, and even opening the exchanges to local governments and municipalities. When joining a private exchange, a state or local government could negotiate an agreement with the exchange to make its workers' existing health plans available on the exchange. Such workers and their families would therefore not be forced to drop the coverage that they have (and may prefer) in any transition.

For many state and local employees, the option of retaining their coverage, with a generous defined contribution, would expand the size of the private exchange pools, reduce administrative costs, and enable workers to take advantage of the plentiful benefits of an even more intensely competitive insurance program. Public employers and unions might even welcome the opportunity to slow cost growth in anticipation of the Cadillac tax, with such “shared savings” divided between

taxpayers and union members (in the form of wage increases, as current New York City contracts envision). This would allow government employers to focus on core issues such as rewarding high productivity and performance, while increasing the transparency of benefit costs for union employees and taxpayers. Indeed, given New York State's current collective bargaining framework, such employees and taxpayers are likely unaware of the impact that the Cadillac tax's high-cost benefit plans will have on them in coming years.

The prospect of joining corporate employees in a competitive private exchange, while keeping their own plans, if they wish, would doubtless be more attractive to state and local workers than being compelled for budgetary reasons, say, to obtain health insurance in the more heavily regulated public exchange. Small businesses could also be allowed to enroll their employees in private exchanges sponsored by the state, offering them immediate benefit of scale.

3. Assist small businesses to self-insure by removing the prohibition on stop-loss insurance.

Ideally, small businesses (firms with 100 workers or fewer) should be able to self-insure, taking full advantage of the more flexible arrangements of a self-insured private exchange serving large employers. This would, however, depend on their ability to purchase a reinsurance ("stop-loss") policy that protects them, as small companies, from excessive financial risk.

At present, New York State bans firms with fewer than 50 workers from purchasing stop-loss insurance coverage. Policymakers should remove this prohibition, and instead base state regulations of stop-loss insurance on the National Association of Insurance Commissioners' Stop Loss Insurance Model Act of 1995.

Conclusion

The private market is not static: private-sector innovators will find ways to navigate today's legal and regulatory obstacles to get better value for their health care dollars. Implementation of the ACA marks the beginning of a major transition in employer-sponsored health insurance,

particularly among large employers. The law imposes an unprecedented mandate on employers with 50 or more full-time workers to provide federally approved levels of coverage or pay a tax penalty. It requires employers to report the insurance coverage and status of their workers; larger employers (with more than 200 workers) are required to automatically enroll their workers in the company plan. In 2018, employers sponsoring high-value health plans will be subject to a formidable 40 percent excise tax on Cadillac health insurance plans.

Government policy will stimulate a powerful market response. New York employers, like employers throughout America, will make fundamental decisions about the provision of health insurance. While they can retain and modify their coverage under the terms and conditions of federal law, they can also drop health insurance coverage altogether, pay the tax penalty, and send their workers and families to the new public exchanges. Official projections by the CBO and the Medicare Actuary of how employers will respond to these challenges have been fairly conservative in their estimates of the loss of job-based coverage. Independent analysts have been far less sanguine about the future of employer-sponsored health insurance.

Rather than drop coverage entirely, employers that wish to stay involved in the provision of health insurance may find that transitioning from a defined-benefit to a defined-contribution model is preferable. The best available platform for making this alternative a reality is a private health insurance exchange. A private exchange can offer employees the opportunity to take advantage of traditional health plans, new benefit designs, revolutionary reimbursement arrangements, and delivery reforms. Genuine employee choice among the insurance products of competing carriers would provide the kind of intense competitive environment that would drive innovation in the delivery of care, increase productivity among health care providers, and achieve higher levels of patient satisfaction.

Business leaders have shown a growing interest in defined-contribution financing and private health insurance exchanges. Policymakers can ease the transition to private exchanges by clarifying state and federal laws. To do so, they must also reverse course on health policy by allowing America's employers and employees to choose what they want, and not have their choices dictated to them.

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Engaging and Empowering Employees with Chronic Illnesses: The Challenge for Consumer-Driven Health Care

Paul Howard, *Manhattan Institute*

We are asking patients to assume increasing financial and cognitive responsibility for their health—and for their health care. This shift, under way for decades, is accelerating in the wake of the passage of the ACA. Average deductibles for employer-based coverage first approached \$1,000 in 2011.¹ By 2014, the average annual deductible for single coverage was more than \$1,200, close to the Health Savings Account (HSA) mandated minimum of \$1,250.² (Deductibles for the most affordable bronze plans on the ACA exchanges are significantly higher.) Indeed, 41 percent of American workers are now covered by plans with a general deductible of \$1,000 or more for single coverage.³

Supporters of the ACA have focused on the law's insurance expansion, but few anticipated what has come to pass: the entrenchment of high-deductible plans and narrow networks on the ACA's public exchanges. Nearly 50 percent of all hospital networks available on the exchanges are "narrow," according to McKinsey. In the largest metropolitan areas, 62 percent of all network offerings are narrow.⁴

Consumers purchasing narrow network plans on the exchanges are somewhat less satisfied with this type of coverage, though few appear to be switching to broader networks.⁵ Broader networks are significantly more expensive (15–23 percent), which may explain the reluctance to switch. Of greater concern is the fact that, in 2015, 44 percent of first-time purchasers of exchange plans did not understand their plan's network design.⁶ Because out-of-network coverage is often highly limited

or nonexistent for these types of plans (the vast majority of plans on New York's exchange did not offer out-of-network coverage in 2015), consumers can face unlimited out-of-pocket costs if forced to consult out-of-network providers of highly specialized care (such as that provided by many academic medical centers).

This development is a largely predictable consequence of legislative choices made during the design of the ACA. Standardized coverage for qualified health plans on the exchanges means that consumers have been left with only two real variables for choosing health plans: network size and premium. In exchange for lower premiums, many consumers appear to have opted for higher deductibles and narrower networks.⁷ The ACA's 40 percent excise tax on high-value plans is further accelerating the re-configuration of traditional health-benefit designs, pushing the public exchange markets and employer-sponsored insurance (ESI) to converge in plans that require consumers to have more skin in the game.

For the median patient (who has less than \$800 in expected annual medical spending) and for the current system (where at least 30 percent of health care spending is likely wasteful or ineffective), greater cost discipline for providers is a good thing.⁸ But how will patients with serious, chronic health conditions be affected?

There is broad recognition that the financial structure of HDHPs has succeeded in helping slow cost growth compared with traditional plans.⁹ There is also evidence that low-income, chronically ill patients with HDHPs may postpone necessary medical care and may be more exposed to significant financial burdens as a result of their conditions.¹⁰ Some patients with HDHPs even reduce consumption of medical services that are 100 percent covered (e.g., vaccinations and primary care screenings) by their plans.¹¹

Accessing specialists and ensuring continuity of care can also be a significant challenge for patients in narrow networks. In 2014, for instance, Memorial Sloan Kettering Cancer Center was covered by only two plans on the New York State exchange.¹² The Hospital for Special Surgery is covered by only four plans.¹³ Given "churn" on the exchanges, as patients change plans to lower premiums or access subsidies attached to benchmark silver plans, patients with serious chronic conditions may have added difficulty in maintaining continuity of care across providers and may experience adverse health consequences from adapting to

different insurers' drug formularies. For narrow networks and HDHPs, short-term savings may sometimes result in worse health and higher costs in the long run.

Yet it is important not to lose sight of the critical benefits that consumerism in health care, including HSAs, can provide for patients with chronic illnesses. As health care becomes increasingly digital and data-driven, patients with chronic illnesses have the most to gain as the system shifts away from fee-for-service and toward value-driven health care—greatly increasing the likelihood that patients can find the right treatment at the right time at the right price.

Indeed, patients with chronic diseases have the most to lose from the U.S. health care system's current inability to standardize and evolve best practices, adopt new innovations in a timely manner, and reconfigure care to meet patients' preferences. For such patients, choosing among providers delivering either the regional "standard of care" (which might not reflect the most recent advances or be tailored to individual patients) or outcomes reflecting the national average often means losing out on excellent care delivered by a handful of innovative providers. Limited consumer access to outcomes data means that exceptional providers, whether across the street or across the country, remain effectively invisible and inaccessible. It also means that lower-performing providers face insufficient incentives to retool their operations to achieve better results.¹⁴

"The Bell Curve," a 2004 *New Yorker* article by Atul Gawande, tells the story of Annie Page, a girl living with cystic fibrosis, a lung disorder that typically kills patients when they reach early adulthood. The present widespread bias, Gawande argues, is to mistakenly assume that most providers offer highly effective care:

The one thing that [Annie's] clinicians failed to tell them, however, was that Cincinnati Children's [hospital] was not, as the Pages supposed, among the country's best centers for children with cystic fibrosis. According to data from that year, it was, at best, an average program. This was no small matter. In 1997, patients at an average center were living to be just over 30; patients at the top center typically lived to be 46. By some measures, Cincinnati was well below average.

The best predictor of a CF patient's life expectancy is his or her lung function. At Cincinnati, lung function for patients under the age of 12—children like Annie—was in the bottom 25 percent of the country's CF patients. And the doctors there knew it.... It used to be assumed that differences among hospitals or doctors in a particular specialty were generally insignificant. If you plotted a graph showing the results of all the centers treating cystic fibrosis—or any other disease, for that matter—people expected that the curve would look something like a shark fin, with most places clustered around the very best outcomes. But the evidence has begun to indicate otherwise. What you tend to find is a bell curve: a handful of teams with disturbingly poor outcomes for their patients, a handful with remarkably good results, and a great undistinguished middle.¹⁵

Patients with serious chronic illnesses represent a small fraction of the U.S. population but account for a disproportionate share of America's health care spending. As Gawande illustrates, outcomes for patients with chronic illnesses vary dramatically, depending on the provider. Elderly patients eligible for hip replacements fare better, at lower cost, when they seek care at hospitals that have lower surgical infection and complication rates and that return patients to full mobility faster. In New York, surgical-site infection rates for hip replacements fluctuate widely, from 0.4 percent at the Hospital for Special Surgery to 4 percent at Jamaica Hospital.¹⁶ Average costs for hip replacements, even for relatively low-risk patients, differ tremendously, too: in 2011, \$18,750 at Jacobi Medical Center—more than twice the rate at Lenox Hill Hospital.¹⁷ Clearly, packaging cost and outcome data in a consumer-friendly format can empower patients to seek out the highest-value care.

For healthy patients, knowing what physicians and hospitals that a prospective insurer covers may be convenient; for patients with serious chronic illnesses, it can be a matter of life or death. Effective cost calculators, such as that provided by the National Health Council, can also help such patients understand their likely medical costs in the following year, using age, health, and prescription drug usage data. After inputting their

information, patients are shown total costs for a variety of exchange-based plans,¹⁸ allowing patients to personalize their insurance purchases, rather than simply choose the lowest-premium plan (which can leave them with thousands of dollars in unnecessary out-of-pocket costs). Cost calculators—useful for all patients shopping on exchanges and, increasingly, used by employers and private exchanges—are nevertheless most important for patients with chronic diseases, where the cost burden associated with high-deductible plans can be far greater.

The only way to know whether an insurer's network or individual provider or hospital is providing high-quality, affordable care is to monitor data; there is no shortcut for transparency on pricing and outcomes. Leveraging data across large patient cohorts makes it possible to use predictive analytics to identify high-performing providers and pass those data along to patients—and other providers. A growing number of vendors now offer analytic approaches, “enterprise health management,” that can be used by public and private employers to predict which patients are likely to face future high-cost health complications and to design effective disease-management and prevention programs to address patient needs at the earliest opportunity. Such analytics offer employers real-time data on how employees access (or fail to access) health information, as well as how they respond to different incentive programs. Since employers now have an excellent opportunity to measure productivity in relation to chronic conditions (such as depression), they are also well positioned to experiment with different reimbursement strategies to incentivize providers to maximize outcomes for chronically ill patients.

The strong business case for transparency on pricing and outcomes—in 2014, U.S. businesses spent \$620 billion on health insurance for employees—makes employers uniquely positioned to pressure policymakers to deliver meaningful transparency and reporting requirements, which can, in turn, be leveraged to secure better contracts with health care providers and insurers.

Competition has a critical role in improving treatment for chronic illnesses. Reimbursement reforms that shift away from fee-for-service and toward value-based payments are realigning providers away from expensive inpatient treatments and are incentivizing focus on primary care and community-based interventions. Employers are now experimenting with telemedicine, on-site clinics, and even the “gamification” of health care to

ensure that patients can access high-quality care and that patients remain engaged in healthy behaviors and compliant with disease-management programs. Employers must press policymakers to reduce regulatory barriers to allow innovative market entrants to meet the needs of chronically ill patients as technology evolves and populations grow.

Finally, when it comes to insurance design, employers must recognize that one size truly does *not* fit all. While high deductibles may be inappropriate for certain patients with chronic illnesses, creating tiered networks (to encourage utilization of more efficient providers), as well as adopting reference pricing and direct contracting with “centers of excellence” (to manage particularly complex or high-cost ailments), can allow employers to lower or eliminate co-payments for patients who access such providers and remain compliant with effective disease-management programs.¹⁹

HDHPs and HSAs are one set of tools available to employers to increase consumer engagement in health care decisions, but there are clearly many other potentially effective options that may better address the needs of chronically ill patients. Whatever tools employers select, the key is to understand that patient empowerment and engagement is the goal. To achieve this, health care information must be delivered in consumer-friendly fashion. Patients with chronic illnesses, like all patients, need to be able to access critical information from their smartphones and tablets, from their social networks, and from trusted intermediaries (such as the American Cancer Society and the Cystic Fibrosis Foundation) best equipped to curate the data.

Market incentives matter, too: innovators will not be rewarded if consumers are insufficiently incentivized to shop around. One commenter noted in the *Harvard Business Review*: “As data clarifies which suppliers and services lead to better health, the market should more clearly signal these data to consumers”—who can, in turn, reward innovators with increased market share.²⁰ Kaiser Permanente, renowned for its focus on patient engagement and delivery of top-notch, evidence-driven care (much through virtual channels), has been rewarded with more than 9 million patients²¹ and distinction as one of America’s most innovative providers. Unfortunately, Kaiser remains an outlier today—but its story will become much more common if the market rewards other innovators appropriately.

While employers' roles are changing as a result of health care reform, they still have a large stake in reorienting the health care system toward better serving patients with chronic illnesses. More than 75 percent of the highest-cost employees suffered from one or more chronic health conditions, while the top 5 percent of highest-cost employees accounted for 50 percent of spending, according to the IMS Institute.²²

Henceforth, employers will do more than simply offer health insurance coverage and wellness and disease-management programs. They will help employees and their families understand how their benefits operate and ensure that the appropriate tools are available—and utilized—to make high-value health care decisions. According to Giovanni Colella, cofounder of Castlight Health:

When an employee can see which doctors provide the best care at the lowest price, they are both more likely to get care they need—saving costs down the line—and to choose higher-value providers. . . . That's a good thing, too, because for American enterprises, this is not just an academic question; it's a fundamental matter of competition and survival. Surveyed [in 2014], most business leaders said that, if they could reduce the cost of healthcare, they would invest the savings in employee wages, innovation, and technology. That's not just good for business; it's good for America as more dollars can be invested (rather than wasted), growing our economy and keeping our people healthy.²³

Consumerism is coming to American health care, in the Empire State and nationwide. Patients with chronic diseases will require a tailored approach from employers; but as long as competition and transparency progress to increase the value delivered to engaged patients, patients with chronic illnesses as well as employers will benefit. Employers' new role is thus more critical than it has ever been: to ensure that consumerism in health care—in HSAs, tiered networks, reference pricing, medical tourism, and in all its other forms—is deployed in service to the health of patients. New York's next health care revolution has just begun.

Endnotes

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2. See IRS, Publication 969 (2014), http://www.irs.gov/publications/p969/ar02.html#en_US_2014_publink1000204025.
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“The essays’ focus on the patient-consumer’s role is what makes this short book so valuable. It lays out a road map for public and private employers to create a level playing field, wherein insurers and providers compete to deliver high-value health care.”

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New York State stands at a watershed moment. A confluence of forces, ranging from the Affordable Care Act to existing trends in the employer insurance market, is beginning to turn millions of patients into “patient-consumers.” The potential for change is vast. Newly armed with accessible information on health care cost, quality, and safety, patient-consumers can be empowered to shop for more affordable insurance and providers. In the process, New York’s opaque, expensive health care system will finally be opened to real competition and transparency.

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Support for this work was provided by the New York State Health Foundation.