



Testimony before the United States Congress  
House Committee on Energy and Commerce  
Subcommittee on Health

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Health Care Solutions  
Increasing Patient Choice and Plan Innovation

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In recent years we've seen health insurance costs continue to increase, while the commercial health insurance options available to consumers have shrunken. More health plans are adopting narrow provider networks and closed drug formularies as a way to hold down costs, while aspects of the health plan market have become less competitive on the whole.

The elephant in the room is how much the Affordable Care Act is to blame for these trends. The truth is that prior to implementation of the ACA, American healthcare was hardly a low cost, high-quality, free market utopia. So however one decides to parse blame for our current challenges -- and I have admittedly been a critic of the ACA since its inception -- my goal today is not to revisit that legislation's pros or cons. Instead I want to briefly consider some of the current trends that we are observing, and offer market based reforms that I believe are universal. They could make the market for coverage more competitive and affordable, whether the ACA remains in force, or we adopt a different framework for healthcare reform.

Toward these ends, today I want to do two things. First, I want to make some brief observations about trends in the insurance market that are occurring both inside and outside the exchanges. These are developments that I believe impede the common goals we seek of fostering a market of high quality and more affordable coverage options. Second, I want to offer some ideas for reforms that I believe can help reverse some of these trends, and make the market for health insurance more robust, competitive, and high value.

## **The Current Market**

Looking at today's market, we're seeing a number of simultaneous trends that I believe are inconsistent with the outcome that we collectively seek. These relate to the breadth and quality of coverage, the cost of healthcare services, and the increasingly narrow economic demographic of consumers who are able to affordably access the existing market.

First, it's now widely recognized that health plans are narrowing provider networks<sup>i</sup> and drug formularies as a way to reduce the cost of their benefits.<sup>ii</sup> Insurers are faced with an increasing number of mandated costs and more limited tools to price and manage their actuarial risk. So the principal tools they retain as a means to reduce costs is to lower the cost of the underlying benefit. While the narrowing provider networks are well documented, there's been far less attention paid to the narrowing of coverage for drugs. By my analysis, almost all of the silver plans have adopted closed formularies.<sup>iv</sup> Many of these closed formularies are coupled to narrow formulary lists. The combination of these two approaches means consumers are increasingly responsible for the full cost of a rising number of drugs, and this consumer spending doesn't count against deductibles or out of pocket limits.

At the same time, the cost of medical care continues to rise at a faster rate than overall inflation. I know a lot of the focus on rising healthcare costs has turned on the price of technology, especially drugs. But the fact is that the real price of drugs, after discounts are applied, is growing, but not at a historically rapid pace.<sup>v</sup> A much bigger factor in rising drug spending overall is not prices, but population-related factors. More people are taking more medicines, especially higher-cost specialty medicines, and in large part, because today's medicines are delivering much more benefit than older drugs, and replacing other healthcare inputs. According to a recent analysis conducted by the Assistant Secretary for Planning and

Evaluation, population growth account for 10% of the increase drug spending between 2010 and 2014. Increased number of prescriptions being written per patient accounted for 30% of this growth. In other words, fully 40% of the increased spending was related to population factors.<sup>vi</sup> Other analysis, for example from Caremark CVS<sup>vii</sup>, has found similar results.

Why is this relevant to our discussion today? Because on the issue of healthcare costs, I would submit to you that an equal if not greater concern should be the consolidation that's underway on the provider side of the market, where local institutions are monopolizing local healthcare providers. This is leaving the delivery side of the market less competitive, in ways that could ultimately limit patient choice and plan innovation. In some instances, deliberate policy steps – some taken by this body -- have encouraged, or at least enabled, this consolidation, often as a vehicle for trying to achieve other goals. The consolidation raises two immediate concerns related to healthcare costs. First, there's a direct concern that as local institutions monopolize the local provision of care, they're able to subvert market based pricing of services and force payers to absorb above market rate increases.<sup>viii ix</sup> The Federal Trade Commission repeatedly expressed misgivings around these possibilities.<sup>x xi xii</sup>

A lot of the data on these outcomes is backward looking. It may understate the scope of the consolidation, which has accelerated in the last few years. A 2012 survey by American Hospital Association showed that between 2000 and 2010, hospital employment of physicians increased by 32%. As of 2012, the majority of physicians were employees instead of owners, according to a survey conducted by the American Medical Association. Nearly 58% of family physicians and 50% of internists identified themselves as employees.<sup>xiii</sup> Similar trends are observed with certain medical specialties, especially cardiology and oncology, where we have seen accelerating consolidation and hospital ownership of medical services. Across these specialties, there's convincing data on the impact consolidation has on costs.<sup>xiv</sup>

The second concern relates to the efficiency of medical care. There's evidence to show that healthcare productivity often declines as providers enter these arrangements where they become employees, typically of large hospital systems.<sup>xv</sup> If we believe that the only way to solve our long term fiscal challenges as they relate to healthcare is to get more and better healthcare for every dollar of GDP that we spend on it, the last thing we should contemplate are policies that will lead to a deliberate reduction in the productivity of healthcare delivery.

There's no reason to assume that the opportunities that many believe are offered by consolidation, whether it's a view that there will be better integration of care or more rapid adoption of healthcare IT, will offset these productivity declines. On the contrary, there's evidence that economic integration between providers and hospitals does not automatically lead to functioning clinical integration. Even after combinations, a lack of alignment between physicians and hospitals can threaten the success of these models.<sup>xvi</sup> Moreover, I believe that many of the sought after goals -- for better integration of care -- could be achieved through a multitude of new arrangements, and not solely by consolidating doctors around hospitals.

### **Pricing More People Into The Market**

The third issue relates to the economic accessibility of coverage purchased outside of employer relationships. It's generally agreed that the state-based exchanges were intended to fully replace the individual market and most of the small group market that existed prior to

the implementation of the ACA. But the data on enrollment suggests that the exchanges are increasingly accessible to a narrowing income demographic. In one part, this is as a result of the rising premium and out-of-pocket costs and in other parts, the way existing subsidies are structured to help offset those costs. As premiums rise, and as more plans adopt very high deductibles and cost sharing as a way to offset mandates and a risk pool that's increasingly costlier than that was anticipated, the benefit itself is becoming less economically accessible to all but those who fall inside a narrowing income range. Typically, it's where special cost sharing subsidies attach.<sup>xvii xviii xix</sup> These are individuals who earn less than 250% of the Federal Poverty Level, but don't qualify for Medicaid. Because of the way the cost sharing subsidies are structured, the zone of affordability may increasingly fall below 200% of FPL.

It's my belief that the continuing rise in premium costs, coupled to the narrowing of coverage and the rising cost sharing, are combining to gradually confine the opportunity to purchase coverage to those who qualify for these cost sharing subsidies. As a consequence, rising portions of the overall pool of people enrolling in the exchanges are those who fall in this income demographic. The end result, if these trends continue, will be a program that is largely an income-based program. To the extent that the ACA intentionally supplanted the individual and small group markets, and largely foreclosed the opportunity to buy other kinds of coverage outside of the new exchanges, if the opportunity to enter the exchanges becomes one that is increasingly narrowed to a very specific income range, it could leave other middle and working class consumers strained to afford coverage outside of ESI.

I am sure that none of these trends are what the law's architects intended. I believe there are ways to structure insurance market reforms that would enable more access to a wider choice of lower cost and high value insurance options, whether it's under the structure of the ACA or under a new model of healthcare reform that creates different pooling mechanisms.

### **More Rating and Regulatory Flexibility When it comes to Insurance Products, to Enable More Competition Between More Innovative Insurance Plan Designs**

I believe that regulatory standards – and how the Centers for Medicare and Medicaid Services is interpreting its own rules – limit the ability of plans to offer innovative designs. This gets to a universal policy issue that's not particular to the ACA. It's something that I believe we should consider within any policy context that aims to reform the insurance marketplace to enable a wider selection of affordable, high value options for consumers.

Because health plans must adhere to a narrow formula in order to fall within the discrete metal tiers stipulated by current law, it limits the ability to offer novel plan designs that may fall outside of these narrow boundaries. In other words, insurers must back their plan designs into the discrete actuarial levels stipulated by law. This leads to an environment where plans are designed from the top down, off actuarial targets, rather than based on a bottom up approach to build off principles that may lead to more innovation in coverage.

I know that the metal tiers and the actuarial values that they represent were meant as a way to simplify the selection of coverage for consumers. And I know there's been some discussion of adopting a new, lower actuarial tier as a way to provide a more affordable option for younger consumers. Instead, I believe that a viable market that encourages

innovation should enable more rating and regulatory flexibility when it comes to health plans, to enable more competition between different approaches to designing health plans.

To these ends, insurers can be required to simply report the actuarial value of their plans, so long as they meet a minimum level of coverage. Instead of making decisions based on rigid targets that are tied to metals, consumers can make choices based on the actual actuarial value of the plan. We should solicit objective research to find ways to express these variables in ways that will reduce confusion and leave consumers more, not less informed.

I trust consumers could be properly educated on the meaningfulness of the actuarial targets and incorporate these variables into their selection process. The metals were meant to simplify these considerations. But in our effort to streamline choices, we also limited them. Tools that allow consumers to estimate how the actuarial value of a plan correlates with practical descriptions of the scope of coverage they'll have for different scenarios have become much more sophisticated. This includes modules already incorporated into the healthcare.gov website. These kinds of tools can help consumers understand the relative value of different actuarial targets, and make comparisons between different actuarial levels.

I believe allowing for more regulatory flexibility around rating and plan design would enable a wider selection of higher value options such as value-based insurance designs, or designs that reduce premium and other costs for consumers that stay with an insurer over time. This can enable health plans to invest in care and build the kind of informational relationship that can lead to better targeting of services. This concept of a vanishing premium would not be able to fit under the existing rating approach, and would be viewed as discriminatory under the current rules. These are just some of the examples where regulatory flexibility enables more innovation. Instead, CMS appears to be moving forward a standardized benefit design that's optional now, but some fear could become mandatory at a future date.<sup>xx xxi</sup> In other words, CMS seems to be moving in the opposite direction, requiring more uniformity between different plan options, and reducing the opportunity to create more genuine choice.

### **Clear Rules on Open Enrollment Periods to Enable a Viable Risk Pool, While Using Incentives Rather than Mandates to Get and Keep People in the Insurance Market**

I know CMS has taken steps in recent months to tighten rules around when consumers must enroll in coverage and close exemptions that let many people enroll “off cycle”.<sup>xxii</sup> Clear enrollment periods, with reasonable penalties for those who pursue coverage outside these windows (coupled to effective verification for those who request a special enrollment period) are an essential part of a well functioning risk pool. We need to maintain some exemptions for people who confront some discrete challenges obtaining coverage during open enrollment periods. But carefully defined enrollment windows can also form a key element of rules that use incentives to encourage people to enter the insurance market, and stay continuously insured, rather than relying on penalties to enable these same outcomes.

As I outlined with colleagues in a report published through the American Enterprise Institute, as part of a comprehensive proposal to reform American healthcare, I believe that protections for people with preexisting conditions could therefore involve rewarding continuous coverage rather than punishing lack of insurance. As we noted, one way to do

this is for the federal government to extend the reach of a long-standing provision of law to ensure that people with preexisting conditions have access to coverage wherever they seek it.

Under this approach, people who maintain continuous insurance coverage (under our plan, measured as three or fewer months without coverage over the preceding three-year period) would be guaranteed access to coverage and protected against higher premiums because of a preexisting condition. Under such an approach, insurers would also be prevented from charging higher premiums to customers with continuous coverage who subsequently develop serious health conditions and from imposing coverage restrictions tied to changes in a person's health status. In other words, people couldn't be dropped from coverage or re-rated, so long as they met the requirement for maintaining continuous coverage. Some consumers would need to receive help to maintain coverage, especially through hardships that might impact their ability to meet premium costs. People would also need to receive waivers from the continuous coverage requirements if they hit certain definable hardships.

The requirement for continuous coverage, as a way to avoid restrictions on the coverage of preexisting conditions, serves as a powerful incentive for people to obtain and maintain coverage. It can form the basis of an effective alternative to using penalties to force people to purchase insurance. Such an approach should be coupled to some mechanism to help offset the cost of those with significant preexisting conditions who haven't already secured continuous coverage, to help them get into the market and maintain that coverage.<sup>xxiii</sup>

Right now, the lack of tightly defined enrollment periods, verification requirements<sup>xxiv</sup>, and fluid exemptions, largely forecloses the ability to use a requirement for continuous coverage as a way to create incentives for people to get into, and stay in, the insurance market. I believe that some of our current cost challenges show the shortcomings that come from not having defined enrollment periods as a way to also help maintain a stable risk pool.

One recent analysis, undertaken to evaluate the impact that special enrollment periods have on the non-group market, confirmed that these constructs serve to skew the overall risk pool, ultimately leading to a higher cost, and a less stable market. In the analysis, which evaluated data from the 2014 insurance enrollment season, claim costs for individuals that enrolled in SEPs were 10% higher than those that enrolled during the standard open enrollment period, and per-month per-member (PMPM) claim costs for SEP enrollees were 24% higher on average during the first three months of enrollment than for OEP enrollees.

In the same analysis, in 2015, the difference in PMPM claim costs increased to 41% for the first three months of enrollment. Moreover, SEP enrollees were found to be 40% more likely, on average, to lapse coverage than those that enroll during the OEP. The scope of the SEPs in the current exchanges (over 30 unique occurrences) far exceeds what's available under ESI, Medicare,<sup>xxv</sup> and presumably what's required to address special circumstances.<sup>xxvi</sup>

### **Subsidies for Risk, not only Need, Including Risk Adjustment that Provides Plans with Incentives to Enroll and Improve Health of People with Serious Conditions**

Any plan to enable more universal access to basic health coverage will have some people who are priced out of the market because they simply don't earn enough to afford qualified health coverage. For these individuals, there must be some mechanism to provide a subsidy

that can help them get into, and stay in, the insurance market. In the plan that I helped co-author that was released by the American Enterprise Institute, my colleagues and I advocate a system of tax credits. These are set initially as fixed-dollar amounts based on age. Under our framework, older individuals would get larger subsidies, reflecting their tendency to use more health services. These subsidies would be sufficiently generous to ensure that people can afford, at a minimum, a basic health plan that provides insurance against serious illness.

Another option is to match the magnitude of the tax credits more closely to the varying costs of care and insurance costs that real purchasers will face in a less-regulated market. This second option would make the tax credit amounts more open-ended initially and responsive to premiums that may vary by age, geography, and perhaps some form of pre-existing risk (through a risk adjustment mechanism). We outline this approach in the plan that we released through AEI. Structuring the tax credits as a uniform fixed percentage of premium costs would provide all purchasers with the same subsidized discount rate in choosing insurance plans. This initial floating cost-based subsidy structure then could be adjusted in later years to set a ceiling on maximum tax benefits (to curb overspending) and add additional subsidies for more economically or medically vulnerable populations.

Under this approach, to qualify for the tax credit, individuals would need to purchase qualified health insurance that would be defined in advance.<sup>xxvii</sup> Among other things, there would need to be a federal requirement that insurance plans purchased with the credit must provide coverage for medical care above an out-of-pocket limit of consumer spending.

Any approach to providing subsidies should be coupled to proper risk adjustment, so that plans have an incentive to enroll individuals with certain pre-existing conditions, and improve their health. Risk adjustment provides an inducement for health plans to seek out people with costlier conditions, and get them better.

CMS took some recent steps to adjust the agency's mechanism for risk adjustment under the Affordable Care Act, by incorporating data on drug utilization as a way to account for the higher cost of caring for patients with certain chronic conditions. It remains unanswered whether these limited steps will have a meaningful impact.<sup>xxviii</sup> It is my belief that in a properly functioning market, plans should be able to profit from the arbitrage that exists between the implicit subsidies that are provided through the risk adjustment, and the actual costs that accrue if health plans are able to meaningfully improve peoples' outcomes.

Insurance is expected to pay for unexpected, random "bad things," like accidents. But, for chronic conditions like diabetes (relatively low but regular costs) or cystic fibrosis (very high and regular costs), actuaries know that there may be a lifetime of extra expenses. To address these costs, risk adjustment chooses a limited number of discrete, ongoing, costly conditions and pay insurers extra for them, in addition to regular premiums from individuals or employers. Proper risk adjustment systems choose a limited number of discrete, ongoing, costly conditions and pay insurers extra for them, in addition to regular premiums from individuals or employers. The approach was used effectively in Medicare Part D.<sup>xxix</sup> Under the ACA, risk adjustment is budget neutral, where insurers who have a large share of chronically ill people receive payments, and other insurers who have fewer than average ill people pay into a "risk adjustment pot" to make the payments.<sup>xxx</sup>

Typically, risk adjustment provides assistance directly to insurers, based on measuring their pool. It's conceivable that risk adjustment could be enabled through a scheme that prospectively bakes some of this assistance into the tax credits provided to consumers to help them buy coverage. One can perhaps eventually envision a system where consumers in a large, well-functioning pool, who suffer from certain costlier conditions, could have their subsidies adjusted automatically (at the time of enrollment) to reflect their higher costs. This can even provide incentive for health plans to recruit such individuals, and actively manage their health and reduce the cost of care. There are plenty of practical challenges and concerns that would arise from such an approach. The designations that follow individuals in such a hypothetical insurance pool, that would indicate the existence of their adjusted subsidies and thus their underlying medical condition, would need to be completely de-identified in advance of enrollment and impenetrable to disclosures. But there are other economic constructs that trade contractual information along with units of value, and that allow these exchanges to be made anonymously. Block chain, for example, incorporates some of these features. In the end, ideally, we want to make risk adjustment prospective.

Unlike the risk adjustment model that's used under the ACA, the scheme adopted by Medicare is prospective. This means it's used to predict costs for the upcoming year based on the mix of conditions an insurer enrolls each year. A prospective model is thought to improve incentives to manage care more efficiently, when this prior data are available. Under such a general framework that incorporates the concept of state-based exchanges for pooling, insurers could agree to a risk adjustment system as a condition of participating in a state exchange. The credit that the health plans receive can be adjusted prospectively, based on a defined set of healthcare conditions and a methodology that the insurers agree to in advance, since they're the ones who know best where the economic sensitivities are.

### **Policies aimed at Creating Additional Opportunities and Incentives for New Plan Formation and Alternative Arrangements to the Consolidation of Providers**

Finally, all health care is local. Once local market competition is made less robust, through the consolidation of providers around single health systems, or the elimination of plan options, the opportunity to rely on competition as a way to improve options and lower costs is reduced. We should take steps to foster more competition in local markets between health plans and providers. This should start by reconsidering some of the policy steps that I believe have fueled the consolidation that's now underway among providers, and policies that have made it more difficult for new health plans to enter the market. At the same time, we can take steps to encourage the formation of new health plans and alternatives to the consolidated health systems that have been the primary purchasers of physician practices. Alternatives would allow doctors to maintain ownership of their practices while forming the larger practice units that can accommodate the new pay reforms that have gained political fashion, most of which favor forms of capitation that transfer actuarial risk to providers.

With respect to health plans, there has been no new net health plan formation since 2008. I believe that a big culprit are the caps on operating margins, that make it hard for new plans to enter the market, even with some of the concessions that are made available to start up plans. New health plans have much higher start up costs over an extended period of time. They must continue to spend a higher proportion of their premium revenue on those costs.

Moreover, caps on operating margins create disincentives to investment capital that might enter these markets to help underwrite the formation of new health plans.

On the provider side, there's incomplete data on the scope of the consolidation that's underway, but we know it is rampant. We need to consider policies to create alternatives to the consolidation of physicians around local hospitals, which in an increasing number of markets is giving single health systems the sort of monopoly position that's going to lead to less competition and higher costs. This starts by eliminating some existing Medicare payment rules that are biased in favor of the hospital-based delivery of outpatient care.

At the same time, new policies can enable virtual entities like practice management firms to negotiate and report on behalf of doctors for purposes of Medicare reporting requirements. Right now, regulation is an obstacle to these arrangements. Government guarantees can also be used to help offset the cost of capital reserves for provider-based integrated delivery vehicles. This would enable provider-led organizations to more easily compete to form the integrated systems that are favored under current law and take capitated risk.

Our health care reforms should be aimed at increasing choice and competition as a way to give consumers more options, and more opportunities to access affordable coverage. We all agree that access to continuous health coverage and good primary care is a basic element of good health care. It's an opportunity that should be available to every American regardless of their economic means. Whether we are aiming to reform our existing framework, or craft an entirely new policy approach to how we encourage consumers to pool risk and shop for coverage, there are some universal principles that should govern any policy prescription. I hope that the concepts that I outlined here today can represent a starting point to some of these concepts, and I'm grateful for the opportunity to present them to the committee today.

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<sup>i</sup> The New Era Of Narrow Networks: Do They Come At The Cost Of Quality? Health Affairs Blog, Bruce Spurlock and Maribeth Shannon. October 13, 2015 <http://healthaffairs.org/blog/2015/10/13/the-new-era-of-narrow-networks-do-they-come-at-the-cost-of-quality/>

<sup>ii</sup> Network squeeze: Controversies continue over narrow health plans. Modern Healthcare, Bob Herman. March 28, 2015 <http://www.modernhealthcare.com/article/20150328/MAGAZINE/303289988>

<sup>iii</sup> Bauman, N., Bello, J., Coe, E., and Parkih, A. "Hospital networks: Evolution of the configurations on the 2015 exchanges." <http://healthcare.mckinsey.com/2015-hospital-networks> McKinsey & Company. Published April 2015. "A study from McKinsey & Company found 70% of plans on the exchange in 2014 featured a limited network, with this composition remaining unchanged into 2015."

<sup>iv</sup> Insurance Plans Are Narrowing Their Drug Coverage. Scott Gottlieb, Forbes.com. December 9, 2015. <http://www.forbes.com/sites/scottgottlieb/2015/12/09/why-your-drug-coverage-is-an-increasingly-hollow-benefit/#65c24d29228d>

<sup>v</sup> Meet the Middlemen Cutting Drug Prices. Bloomberg Business Week. Max Nisen, May 5, 2016. <http://www.bloomberg.com/gadfly/articles/2016-05-05/pharmacy-benefit-managers-cut-drug-prices-and-choices>

<sup>vi</sup> ASPE Report: <https://aspe.hhs.gov/sites/default/files/pdf/187586/Drugspending.pdf>

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- vii CVS Health Reports Dramatic Drop in Prescription Drug Trend to 5 Percent, Despite Rising Drug Prices. February 23, 2016. <https://cvshealth.com/newsroom/press-releases/cvs-health-reports-dramatic-drop-prescription-drug-trend-5-percent-despite>
- viii Differing Impacts of Market Concentration on Affordable Care Act Marketplace Premiums. R. M. Scheffler, D. R. Arnold, B. D. Fulton et al. Health Affairs, May 2016 35(5):880–88. <http://www.commonwealthfund.org/publications/in-the-literature/2016/may/differing-impacts-market-concentration-aca-marketplace-premiums>
- ix Hannah T. Neprash, Michael E. Chernew, Andrew L. Hicks, Teresa Gibson, Michael M Williams. Association of Financial Integration Between Physicians and Hospitals With Commercial Health Care Prices. JAMA Intern Medicine, October 19, 2015. <http://archinte.jamanetwork.com/article.aspx?articleid=2463591>
- x F.T.C. Wary of Mergers by Hospitals. Robert Pear, The New York Times. September 17, 2014
- xi Is the System Really the Solution? Operating Costs in Hospital Systems. Lawton Robert Burns, Jeffrey S. McCullough, Douglas R. Wholey, Gregory Kruse, Peter Kralovec, Ralph Muller. Medical Care Research Review. April 22, 2015
- xii Speech by Deborah L. Feinstein, Director of the Bureau of Competition, Federal Trade Commission. Antitrust Enforcement in Health Care: Proscription, not Prescription. Fifth National Accountable Care Organization Summit, Washington, DC. June 19, 2014. [https://www.ftc.gov/system/files/documents/public\\_statements/409481/140619\\_aco\\_speech.pdf](https://www.ftc.gov/system/files/documents/public_statements/409481/140619_aco_speech.pdf) - “Much has been written about the ongoing wave of provider consolidation in health care markets. A growing body of literature suggests that providers with significant market power can negotiate higher-than-competitive payment rates... certain ACO design features or behavior may raise red flags for the antitrust agencies, especially for ACOs coupled with high market shares or other indicia of market power”
- xiii Monopolizing medicine: Why hospital consolidation may increase healthcare costs. Scott Baltic, Medical Economics. February 24, 2014. <http://medicaleconomics.modernmedicine.com/medical-economics/content/tags/hospital-employment/monopolizing-medicine-why-hospital-consolidation-?page=full>
- xiv The impact of provider vertical consolidation on outpatient prescription drug-based cancer care spending. Rena M. Conti, Mary Beth Landrum, Mireille Jacobson. “We estimate a one percentage point increase in the proportion of medical providers affiliated with a health system is associated with a 5-22 percent increase in one year lagged inflation adjusted average per person annual spending and a 3-7 percent increase in one year lagged inflation adjusted prices for cancer treatment. The spending results appear partially but not solely driven by price increases... the main results that provider consolidation increases one year lagged spending and price for outpatient oncology treatment are robust to a variety of sensitivity checks on key variable definitions and inclusion and sample restrictions.” <file:///Users/ScottGottliebMD/Downloads/Impact-of-provider-vertical-consolidation.pdf>
- xv See Cory Capps, David Dranove, Walter J. McNeerney, Christopher Ody. The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending. The Institute for Policy Research Northwestern University Working Paper Series. February 2015 <http://www.ipr.northwestern.edu/publications/docs/workingpapers/2015/IPR-WP-15-02.pdf> and Lawton Robert Burns and Ralph W. Muller. Hospital-Physician Collaboration: Landscape of Economic Integration and Impact on Clinical Integration. Milbank Quarterly 2008;86:375–434 and Gosden T, Forland F, Kristiansen IS, Sutton M, Leese B, Giuffrida A, Sergison M, Pedersen L. Impact of payment method on behavior of primary care physicians: a systematic review. Journal of Health Service Research Policy 2001 Jan;6(1):44-55 Advisory Board, 1999 and Gosden T, Forland F, Kristiansen IS, Sutton M, Leese B, Giuffrida A, Sergison M, Pedersen L. Capitation, salary, fee-for-service and mixed systems of payment: effects on the behavior of primary care physicians. Cochrane Database Systematic Reviews 2000;(3) and Douglas E. Hough, Kai Liu, David N. Gans. Size Matters: The Impact of Physician Practice Size on Productivity Innovation and Research, Medical Group Management Association. JEL Classification Codes: I11, D24 and Douglas E. Hough, Kai Liu, David N. Gans. Size Matters: The Impact of Physician Practice Size on Productivity Innovation and Research, Medical Group Management Association. JEL Classification Codes: I11, D24
- xvi What We’ve Learned from Horizontal and Vertical Integration of Physicians. Lawton R. Burns and Aditi Sen. Advances in Health Care Management’s Annual Review of Health Care Management, April 25, 2014.
- xvii Is ACA Coverage Affordable for Low-Income People? Perspectives from Individuals in Six Cities. Kaiser Family Foundation Issue Brief. April 2016. Jennifer Tolbert, Robin Rudowitz, and Melissa Majerol. <http://files.kff.org/attachment/issue-brief-is-aca-coverage-affordable-for-low-income-people-perspectives-from-individuals-in-six-cities> “Participants expressed concern about their ability to afford the out-of-pocket costs related to their plan deductibles, especially those participants with higher deductible plans. Nearly all

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participants reported their plan included an annual deductible that required them to pay out of pocket for services before their insurance would take effect. These deductibles ranged from less than \$500 to over \$6,000 for those with individual coverage and double these amounts for those with family coverage. When asked whether they could afford their full deductible, if needed, responses varied. While some said no, others had included the deductible in the calculation of their costs for the coverage and felt they could afford it. For participants enrolled in high deductible bronze plans, the costs associated with the deductibles prevented them from getting care they felt they needed”

<sup>xviii</sup> High patient cost-sharing is the elephant in the room during election. Harris Meyer, Modern Healthcare. May 4, 2016. <http://www.modernhealthcare.com/article/20160504/BLOG/160509960/blog-high-patient-cost-sharing-is-the-elephant-in-the-room-during>

<sup>xix</sup> The increasing instability of Obamacare. James C. Capretta, April 22, 2016. <http://www.aei.org/publication/the-increasing-instability-of-obamacare/> “But households with incomes above about 250 percent of the poverty line already find the plans offered on the ACA exchanges unattractive. Very few of these households have purchased plans through the exchanges.”

<sup>xx</sup> ACA Standardized Plans, Star Ratings Pilot to Start in 2017. Sara Hansard, Bloomberg, May 2, 2016

<sup>xxi</sup> Proposed Benefits And Payment Rule Includes Standardized Plans, New Network Adequacy Standards. Timothy Jost, Health Affairs Blog. November 20, 2015 <http://healthaffairs.org/blog/2015/11/20/proposed-benefits-and-payment-rule-includes-standardized-plans-new-network-adequacy-standards/>

<sup>xxii</sup> On January 19, 2016, CMS issued new guidance regarding special enrollment periods that will no longer be used by the federal and state-based marketplaces and outlined future regulatory action on special enrollment periods. CMS also stated that the agency will conduct assessments of two frequently used special enrollment periods (related to loss of minimum essential coverage and permanent moves) to validate their proper use.

<sup>xxiii</sup> Improving Health and Health Care, an Agenda for Reform. The American Enterprise Institute, Joseph Antos, James C. Capretta, Lanhee J. Chen, Scott Gottlieb, Yuval Levin, Thomas P. Miller, Ramesh Ponnuru, Avik Roy, Gail R. Wilensky, and David Wilson. December 2015. <https://www.aei.org/wp-content/uploads/2015/12/Improving-Health-and-Health-Care-online.pdf>

<sup>xxiv</sup> In an Interim Final Rule that CMS released May 6, 2016, the agency would require individuals who try to get coverage via SEPs due to a permanent move have to show prior coverage was in effect

<sup>xxv</sup> <http://www.medicareinteractive.org/wp-content/uploads/2015/08/SEP-Chart.pdf>

<sup>xxvi</sup> Oliver Wyman, Special Enrollment Periods and the Non-Group, ACA-Compliant Market. Chris Carlson and Kurt Giesa, February 24, 2016.

<sup>xxvii</sup> Defined as any insurance that covers “medical care,” such as major medical, or other definitions of qualified coverage as determined in the state of purchase.

<sup>xxviii</sup> Bronze Woes Raise Flags That Issuers Could Drop Entire Metal Tier. Inside Health Policy, May 3, 2016. “Stakeholders are mixed on whether CMS’ proposed risk assessment changes could avert the potential departure of bronze options. The consultant who asked to remain unnamed believes the proposed changes are largely useless and -- with the possible exception of adding drug use data -- won’t sway the market in a new direction.”

<sup>xxix</sup> Starting with Medicare private policies (now called Medicare Advantage), CMS began using inpatient diagnostic information for risk adjustment in 2000, and then improved the precision of the risk-adjustment system with the addition of professional encounter data for chronically ill people in 2004. The ACA has now carried this approach forward to the individual and small-employer markets

<sup>xxx</sup> What Risk Adjustment Does — The Perspective Of A Health Insurance Actuary Who Relies On It. John Bertko, Health Affairs, March 29, 2016 <http://healthaffairs.org/blog/2016/03/29/what-risk-adjustment-does-the-perspective-of-a-health-insurance-actuary-who-relies-on-it/>