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WEDNESDAY SEPTEMBER 12, 2012*****



**Implementation of the Affordable Care Act's
Health Insurance Exchanges and Related Issues**

by

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**for the
House Ways and Means Committee
Subcommittee on Health**

September 12, 2012

I. Introduction

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

We appreciate this opportunity to testify on the development of health insurance exchanges and other issues surrounding the implementation of the Affordable Care Act (ACA). Our members are strongly committed to competing in the new marketplace and offering high quality, affordable coverage options to consumers who shop in the exchanges. Health plans also have been active partners in supporting states in their efforts to develop state-based exchanges, while also assisting states that will partner with or utilize the federal exchange.

Following the enactment of the ACA, health plans have been working diligently to comply with the thousands of pages of regulations, directives, information requests, guidance, and other regulatory documents that HHS and other federal agencies have issued to implement various statutory provisions, including rate review, rate disclosure, medical loss ratios (MLR), federal external review, internal claims and appeals, grandfathered health plans, lifetime and annual benefit limits, coverage of preventive services, coverage of adult children to age 26, the consumer web portal, pre-existing condition exclusions for children, and access to emergency services. Working closely with our member plans, we have submitted detailed comments and recommendations to the Department of Health and Human Services (HHS) and other agencies in response to the regulatory guidance that has been issued.

Health plans also have responded to data calls to populate the federal health insurance plan finder at healthcare.gov, provide additional information to complete the Summary of Benefits and Coverage (SBC) documents, and submit product details to identify potential essential health benefits benchmark plans, among others. These requirements only will increase as insurers comply with new bulletins, guidance and data collection reporting requirements and prepare for the transformed individual and small group insurance markets, both inside and outside the health insurance exchanges.

As our members prepare for implementation of the exchanges in January 2014 and the initial statutory open enrollment period in October of next year, there is a tremendous amount of work that needs to be done in the intervening months. As we discuss below, it is critically important for HHS to issue clear regulatory guidance on a number of key issues as soon as possible to ensure that health plans, states, and other stakeholders can meet these deadlines. The following sections highlight key implementation issues and our recommendations for accomplishing the five goals we have been discussing with the Department, the National Association of Insurance Commissioners (NAIC), and state officials:

- Minimizing disruptions for consumers, businesses, states, health plans, and other stakeholders as we transition to the new health insurance exchanges;
- Ensuring the workability of the operational architecture of exchanges and allowing state flexibility;
- Maximizing coordination to prevent redundant state and federal regulations and data collections and focusing on ways to reduce the administrative cost burdens;
- Maximizing choice and competition; and
- Addressing specific ACA provisions to make health coverage more affordable for consumers and purchasers.

II. Urgent Need for Regulatory Clarity on Key Issues

We begin by emphasizing that there is an urgent need for more regulatory clarity with respect to exchanges and insurance market reforms. Health plans, states, and other stakeholders need clear regulatory guidance on a number of key ACA provisions including:

- Comprehensive insurance market reforms (guaranteed issue, adjusted community rating, pre-existing condition exclusions, geographic rating areas) – awaiting proposed rule. Health plans must have clear guidance on how these new market rules will be applied both inside and outside the exchange to appropriately develop and price products.
- Essential health benefits (outlining the benefit package provided to consumers) – bulletin released in December 2011; FAQs and other guidance released; awaiting proposed rule. Health plans must have clear guidance on EHB requirements to develop products that qualify

for individual and small group coverage both inside and outside the exchange.

- Cost-sharing reductions (details on how cost-sharing subsidies for consumers will be implemented) – bulletin released in February 2012; awaiting proposed rule. Health plans must have clear guidance on how to develop additional products on the silver tier that will meet the CSR requirements.
- Availability of the actuarial value calculator (simplified means for health plans to compute and report actuarial value) – awaiting beta version of calculator. Health plans must have clear guidance on how to accurately calculate the actuarial value of the plans they intend to offer in the individual and small group markets both inside and outside the exchange.
- Specific parameters for the risk mitigation programs, including reinsurance, risk adjustment, and risk corridors (risk-adjustment model and methodology and annual notice of benefit and payment parameters). Health plans must know the specific risk adjustment methodology and parameters for reinsurance and risk corridors to appropriately price their products.
- Additional details on the certification standards for qualified health plans (health plan quality reporting requirements on activities that improve health outcomes and patient safety) – awaiting proposed rule. Health plans must know all the requirements necessary to be certified as a QHP to develop products appropriately.

Clear regulatory guidance in each of these areas is needed in the very near future. Unless such guidance is forthcoming, it will be difficult for health plans to complete product development, fulfill network adequacy requirements, obtain necessary state approvals and reviews, and ensure that their operations, materials, training and customer service teams are fully prepared for the initial open enrollment period that begins on October 1, 2013.

III. Development of Health Insurance Exchanges

The ACA requires the creation of health insurance exchanges that are intended to function as a new marketplace where individuals and small businesses can purchase health coverage. Because exchanges are such a critical component of the health reform law, the way they are structured and how smoothly they operate – particularly during the first year – will be a major factor in determining whether the law is effective in meeting the health care needs of individuals and small businesses. In an effort to ensure that the exchanges work efficiently and effectively, we have offered several key recommendations to HHS.

Reducing the Administrative Cost Burden of Data Collection Processes

At the same time health insurers are required to meet caps on their administrative expenses, the amount of data being collected by regulators – a process that involves significant costs and manual efforts in some cases – has dramatically increased. For example, health plans have provided information to populate the federal health insurance plan finder (at healthcare.gov) on all of their plans in the individual and small group markets. This process involves plans submitting 169 unique data points for each of their individual market plans.

Health plans also have been required to provide additional data to align with the new Summary of Benefits and Coverage (SBC) regulation, a new and costly administrative requirement on health plans. Notwithstanding all of the data already provided, health plans have been asked to submit data again as part of the effort to identify potential benchmark plans. To manage all of the separate data collections coming from HHS, each requesting that data be submitted in slightly different ways, health plans have had to create new departments and devote considerable resources to these activities. Moreover, additional administrative burdens will result from state-based exchanges developing their own unique data collection processes. This effort will further expand next year as insurers resubmit their plans that will go into effect in 2014.

Given the financial costs and personnel commitment required to meet these requests at the operational level, we have recommended that the Department review the costs of any new data requirements to minimize duplication of effort and maximize coordination with states. We know that state regulators also are concerned about administrative costs. We appreciate that they and the Department are discussing methods to better coordinate and identify ways to reduce administrative burdens on insurance companies through the System for Electronic Rate and Form Filings (SERFF), which is managed by the NAIC. Going forward, it is critical that data collected from health insurers are collected only to fulfill a statutory purpose and, in such cases, are collected once and electronically shared with other entities that also need the data.

Allowing All Health Plans That Meet QHP Certification Standards to Compete in Exchanges

To participate in an exchange, a health plan must be certified as meeting specific requirements as part of a comprehensive “qualified health plan” (QHP) application process. This process includes a comprehensive review of a health plan’s ability to provide coverage to consumers in the exchanges and meet the full scope of ACA regulatory requirements. For example, as part of

the certification process, health plans must be licensed and in good standing with the state, have an adequate network of hospitals and doctors in their networks including essential community providers, retain accreditation with standards-setting organizations that measure quality, and be in compliance with the other provisions of the ACA (e.g., essential health benefits) and state law.

We support the decision by HHS to certify a health plan as a QHP that meets all certification standards within the context of the federally-facilitated exchange for 2014. We recommend that this approach be extended to future years to ensure a robust marketplace and a wide array of health plan choices for individuals, families, and small businesses. Recognizing that the ACA certification requirements provide an extensive review of health plans, we believe consumer choice and competition would be severely limited by additional criteria that limit the number and types of coverage options that are available to consumers in the exchanges.

Implementing Common Data Standards to Reduce Administrative Costs and Streamline Enrollment

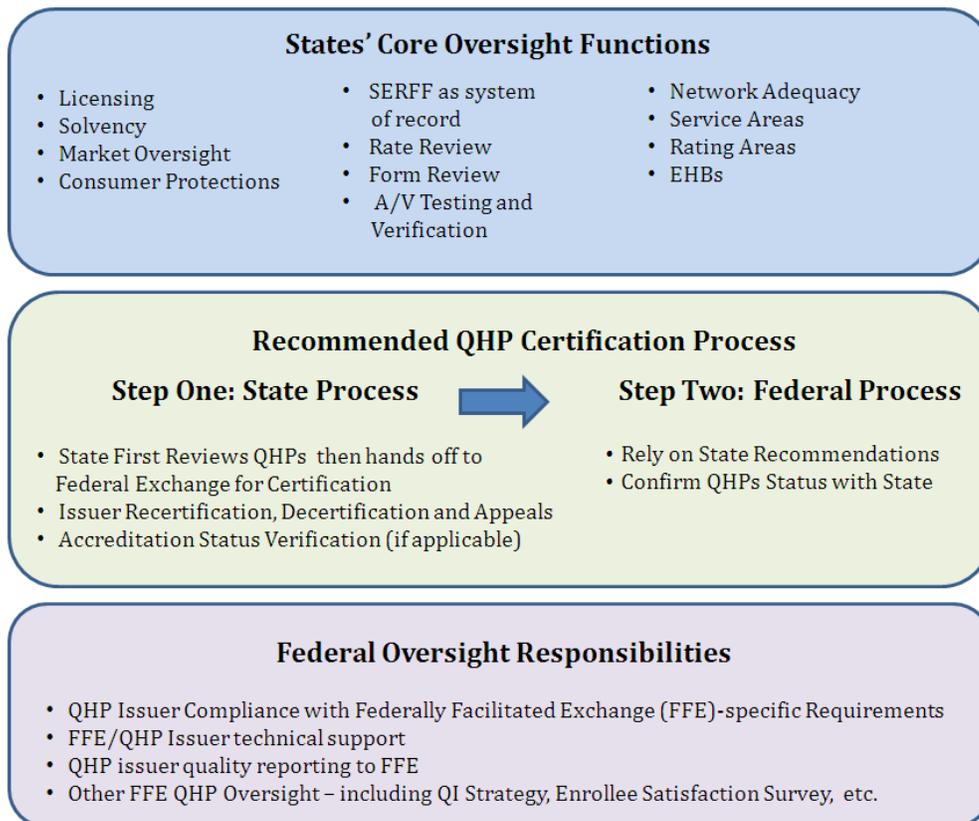
To ensure a streamlined open enrollment period next year, one of the most crucial partnerships between the federal government and the states involves the implementation of common information technology standards for how exchanges will communicate with the federal government and with health plans. The adoption of common standards across all exchanges will reduce administrative burdens and manual “workarounds,” reduce exchange implementation costs, and ensure that the enrollment process is as consumer friendly and efficient as possible – meaning that health care coverage starts on time in January 2014 and no one falls through the cracks.

We believe these standards should be adopted across all exchanges, given that AHIP’s members will be working to support multiple state exchanges. For example, it would be operationally infeasible for a state to send enrollment data to a plan one way and the federal exchange to send it another way, given that all the data has to match up for the tax filing season for individuals receiving premium assistance tax credits. Another area where standards are needed is for the application used by health plans to submit their rates and benefits to the exchange. It is inefficient for health plans to use one format to submit data to state regulators and another format to submit data to the exchange. We know that all of these issues are being considered now and have urged that uniform standards be established and be available as soon as possible, since it takes time to adequately build the systems and processes necessary to support the consumer/purchaser selection processes.

Avoiding Duplicative Regulation by Leveraging Existing State Resources

We appreciate the agency’s comments that its objective is to minimize duplication of efforts in the administration of an exchange. To avoid the duplication of exchange functions and keep costs affordable, we believe there is an opportunity to take advantage of existing state resources and expertise in areas such as rate review and QHP certification. Where state systems are already in place, they should be utilized instead of creating parallel federal systems. This means that to the maximum extent possible, federally-facilitated exchanges should leverage the state’s existing review process and authority by depending on state departments of insurance as illustrated below:

Model for QHP/Exchange Oversight



The success of exchanges will be highly dependent on the creation of a QHP certification process that does not create duplicative regulatory reviews, is consistent with existing state requirements, and is nimble and flexible to ensure that all QHPs receive all necessary approvals in a timely manner. AHIP has provided comments to HHS outlining recommendations for

removing uncertainty from the QHP certification process and ensuring that all necessary approvals are granted in a timely, coordinated, and streamlined fashion.

Specifically, we have recommended that exchanges adjust the QHP certification process to make state review and approval the first step in the process. Following state approval, the exchange could then conduct its review of any QHP-specific requirements. This more streamlined approach would eliminate the unnecessary duplication of review between the Department and the states.

Utilizing Health Plan Expertise in the Performance of Certain Exchange Functions

Another way to improve the efficiency of exchanges – and also avoid added costs and complexity – is to utilize the experience and expertise of health plans. Health plans have been performing many of the same functions of exchanges for many years. We recommend that existing health plan resources are leveraged to both reduce the cost of exchange implementation and increase the speed of implementation. While the specific functions that would be appropriate for plans to perform may vary from state to state, the following are examples of the types of exchange functions that could be handled very effectively by health plans.

Exchange Functions That Can Be Provided by Health Plans

OUTREACH:

- Hosting applications for insurance coverage via web and paper; and
- Responding to certain calls and inquiries.

PLAN SELECTION AND ENROLLMENT:

- Maintaining accurate enrollment status information;
- Hosting provider directories;
- Calculating cost-sharing and enrollee out-of-pocket expenses; and
- Supporting enrollment in a qualified health plan.

POST-ENROLLMENT:

- Managing disenrollments and termination of coverage;
- Managing premium payments and related issues;
- Receiving and reconciling premiums from small employer groups;
- Tracking and resolving complaints, appeals, and grievances by individuals and employers;
- Engaging in fraud detection;
- Handling additional analytical reporting, supporting risk adjustment analysis, and supporting cost analysis; and
- Handling certain website functions, correspondence and notifications, call centers, and inquiries.

Ensuring Consumers and Small Businesses Coverage Options Outside of an Exchange

Exchanges should not be built or expected to serve as the only option for obtaining coverage in the individual and small group markets, but function as another competitive channel to encourage individuals and businesses to purchase coverage in states and across the nation. Those who have coverage today, and who are satisfied with that coverage, should be able to keep that coverage. In the future, consumers seeking coverage should have options available both through the exchange and through new and existing products outside of the exchange.

By way of example, in Massachusetts most individuals and small businesses finding access to and enrolling in coverage are doing so outside of the exchange. According to the latest statistics from the Massachusetts Health Connector, 3-5 percent of the total insured population in Massachusetts is enrolled through the exchange. Out of the 4,586,765¹ individuals with health coverage in the group and non-group markets, 157,579 are enrolled through Commonwealth Care (subsidized coverage) and 43,731 individuals are enrolled through Commonwealth Choice (non-subsidized coverage).

Exchanges should be established in the market to serve as an additional opportunity for individuals and businesses to access coverage. Consumers should continue to have access to the coverage options they have today.

IV. Affordability of Coverage

In addition to focusing intensely on the mechanics of implementing the exchanges and other major health reforms in 2014, our members also believe it is critically important for policymakers and stakeholders to prioritize the issue of affordability. Health plans long have supported the goal of expanding health coverage to all Americans, but this goal can be achieved only if coverage is affordable. As implementation proceeds and health plans develop coverage options for consumers, it is essential to look at provisions that were included in the ACA that will have an unintended consequence of increasing costs. While the law expands coverage to millions of Americans and provides important subsidies, specific provisions of the law will have unintended consequences for consumers and employers. We examine three such provisions: the health insurance premium tax, the minimum coverage requirements, and the age rating bands.

¹ Commonwealth of Massachusetts. "Key Indicators: Quarterly Enrollment Update: June 2011 Edition." February 2012. <http://www.mass.gov/eohhs/docs/dhcfp/r/pubs/12/2011-june-key-indicators.pdf>

Unless these issues are revisited, the cumulative effect of these and other provisions will result in higher costs and potential coverage disruptions. At the same time, to improve health outcomes and patient safety and slow the growth of health care spending, we need a system-wide commitment to build upon the innovative delivery system and payment reforms that health plans have pioneered. Government in its role as a payer implementing payment and delivery system reforms should build on successful programs in the private sector. For example, when uniform or dominant models exist in the private sector such as the patient-centered medical home, Medicare could adopt the existing model rather than pursue a different approach. The Centers for Medicare and Medicaid Services collaborated with ongoing private sector medical home efforts when they launched their Multi-Payer Advanced Primary Care Practice demonstration project. Similar collaborations are needed with other programs and initiatives between the public and private sectors. To make such public-private collaboration a reality will require additional building blocks, such as a common approach to performance measurement and administrative simplification.

Health Insurance Premium Tax

Beginning in 2014, the ACA will impose a new health insurance premium tax that will exceed \$100 billion over the next ten years. The tax begins at \$8 billion in 2014, rises to \$14.3 billion in 2018, and increases annually based on premium growth thereafter. While the tax is assessed on health plans, experts agree that it will impact consumers and employers that purchase coverage directly from a health insurance plan in the individual and group markets as well as beneficiaries in public programs. The Congressional Budget Office (CBO) has stated that this tax will be “largely passed through to consumers in the form of higher premiums.”²

An actuarial study³ by the Oliver Wyman firm, commissioned by AHIP, examined the impact the premium tax will have on employers and families purchasing coverage in different segments of the commercial market. This analysis found that average premiums will increase by as much as 2.8 to 3.7 percent due to the new tax – increasing the cost of family coverage in the small group market by about \$6,800 over a 10-year period. The Joint Committee on Taxation also found the

² CBO letter to Sen. Even Bayh. “An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act.” 30 November 2009.

³ Carlson, Chris. “Estimated Premium Impacts of Annual Fees Assessed on Health Insurance Plans.” Oliver Wyman. 31 October 2011.

new tax to have an impact on premiums and estimated that repealing the ACA's health insurance premium tax would reduce health insurance premiums by 2.0 to 2.5 percent in 2016.⁴

The Oliver Wyman study found that the premium tax is likely to increase costs – through higher premiums or higher cost-sharing – for beneficiaries enrolled in Medicare Advantage plans and Medicare Part D prescription drug plans. Medicare Advantage plans will pay between \$16-\$20 per member per month in 2014 and up to \$32-\$42 per member per month in 2023 as a result of this tax. For Medicare Part D plans, the tax will increase premiums by an estimated \$9 in 2014 and \$20 in 2023 for a total increase of \$161 over 10 years. In addition, the tax will put even greater pressure on state Medicaid budgets by increasing the average cost of Medicaid coverage by an estimated \$1,530 per enrollee between 2014-2023.

To avoid these outcomes, we strongly support bipartisan legislation, H.R. 1370, that would repeal the ACA's health insurance premium tax. We applaud Congressman Charles Boustany for introducing this bill, and we thank the 193 House members who have cosponsored this important legislation.

Minimum Coverage Requirements

Beginning in 2014, the ACA will require health plans to provide coverage for an essential health benefits (EHB) package covering a broad range of mandated benefits, some of which are not typically included in individual and small group policies today. The ACA further requires that coverage sold through the exchanges must be at one of four actuarial value levels: 60% (bronze); 70% (silver); 80% (gold); and 90% (platinum). As a result of these provisions, millions of people may be forced to purchase health insurance that is more comprehensive – and more expensive – than they currently have.

We believe that the EHB package must be affordable for families and small businesses and that affordability should be the cornerstone of consideration in defining the EHB package. The non-partisan Institute of Medicine – in its recommendations to HHS – underscored the need to ensure affordability in defining the EHB standard and cautioned that “if cost is not taken into account, the EHB package becomes increasingly expensive and, individuals and small businesses will find it increasingly unaffordable. If this occurs, the principal reason for the ACA – enabling people to purchase health insurance, and covering more of the population, will not be met.”⁵

⁴ See JCT Letter to Senator Jon Kyl. 12 May 2011.

⁵ IOM Report—*Essential Health Benefits: Balancing Coverage and Cost*. 7 October 2011.

The imposition of broader benefit packages than what consumers and small businesses are purchasing today will force consumers to “buy up” coverage that they may not want or need. In recent months, many state departments of insurance and state exchange boards have requested formal actuarial and economic forecasts of the impact of the new insurance reforms on their state. These independent studies have found that several provisions, including the EHB and actuarial value requirements, will result in higher premiums. The following chart indicates the estimated impact of the EHB requirements from these independent state studies.

Individual Market: Independent State Studies Show “Buy-Up” Due to Federal EHB Requirement	
State	Increase in Non-Subsidized Premiums
Alaska ⁶	3.2%
Colorado ⁷	8%
Indiana ⁸	20%-30%
Ohio ⁹	20%-30%
Oregon ¹⁰	8%
Maine ¹¹	33%
Maryland ¹²	8%-10%
Minnesota ¹³	8%-11%
Nevada ¹⁴	3%
Wisconsin ¹⁵	6%-7%

⁶ Lewis & Ellis Inc. Design Options for a Health Insurance Exchange – Actuarial Analysis; June 2012. Prepared for the Alaska Department of Health and Social Services Division of Health Care Services.

⁷ Jonathan Gruber. Colorado Health Benefit Exchange Background Research. January 2012. Prepared for the Colorado Health Benefit Exchange.

⁸ Milliman. Individual and Small Group Premium Changes Under the ACA; May 2011. Prepared for the Indiana Health Care Exchange Policy Committee.

⁹ Milliman. Assist with the first year of planning for design and implementation of a federally mandated American Health Benefit Exchange; 31 August 2011. Prepared for the Ohio Department of Insurance.

¹⁰ Wakely Consulting Group. Actuarial Analysis: Impact of the Affordable Care Act (ACA) on Small Group and Individual Market Premiums in Oregon; 31 July 2012. Prepared for the State of Oregon.

¹¹ Jonathan Gruber and Gorman Actuarial. The Impact of the ACA on Maine’s Health Insurance Markets; 31 May 2011. Prepared for the Maine Bureau of Insurance.

¹² Oliver Wyman. Potential Impact of the Affordable Care Act on the Current Individual and Small Group Markets; 16 June 2011. Prepared for the Maryland Health Care Commission.

¹³ Jonathan Gruber and Bela Gorman. Coverage and Financial Impacts of Insurance Market Reforms in Minnesota; 17 November 2011.

¹⁴ Gorman Actuarial. Nevada Health Insurance Market Study; March 2012. Prepared for the State of Nevada.

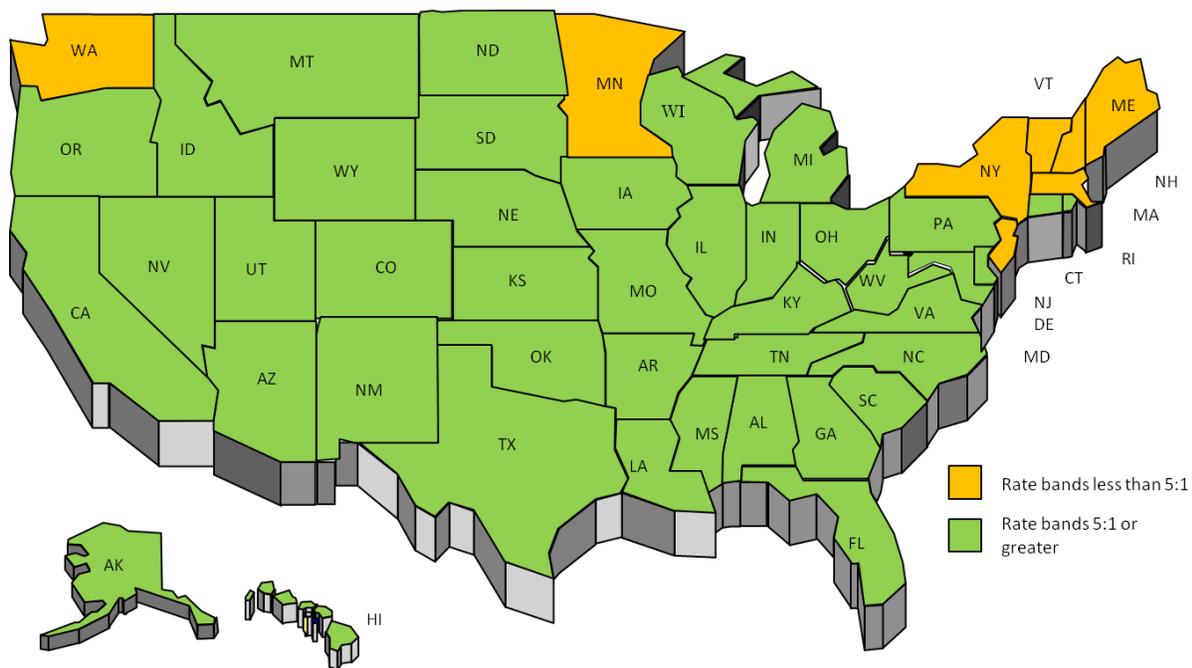
¹⁵ Jonathan Gruber and Jennifer Smagula. The Impact of the ACA on Wisconsin’s Health Insurance Market; 18 July 2011. Prepared for the Wisconsin Department of Health Services.

Recognizing that these ACA provisions will have a major impact on the cost of coverage, we believe that the important goals of the EHB package can be met if HHS and the states place a high priority on offering affordable coverage options to consumers. In addition, consideration should be given to lowering the minimum actuarial value for coverage sold in the exchanges to ensure the availability of affordable coverage options and to allow smoother transitions to the new benefits packages.

Age Rating Bands

Beginning in 2014, the ACA will allow health insurance rates to vary, based on an enrollee's age, by a ratio of no more than 3 to 1 (3:1). This is a dramatic change from the "age bands" of 5 to 1 (5:1) or more that are currently effective in 42 states.

Allowable Age Rating Bands by State



In these states, current state policies on age rating recognize that utilization of health care services is correlated with age and that health insurance only works if younger and healthier consumers are part of the risk pool. An age band of 5:1 strikes a careful balance between these goals by providing protection to older consumers without making it unaffordable for younger consumers to purchase insurance.

We are deeply concerned that the ACA's restrictive age band will cause premiums to increase dramatically for younger people, increasing the likelihood that younger, healthier people will wait to purchase coverage until after they get sick or injured. To protect young people from dramatic cost increases, we believe the ACA's age rating requirement should be replaced with a 5:1 age band. This change in policy will prevent rate shock for younger individuals and families, encourage enrollment by consumers aged 18-34, and maintain cost stability for people of all ages.

Greater Focus on Delivery System and Payment Reform

Health plans have a track record of partnering with hospitals and physicians to reform the payment and delivery system to advance the National Quality Strategy's three aims of achieving better care for individuals, better health for populations, and lower cost growth. Health plans also have pioneered innovative programs and services to coordinate care for patients with multiple chronic conditions, help patients manage chronic disease, and promote prevention and wellness.

These initiatives have proven to be highly successful in improving health outcomes, promoting patient safety, and lowering health care costs. In particular, health plans have prioritized reducing preventable hospital admissions, readmissions, and emergency room visits. To ensure patients are getting appropriate follow-up care, health plans offer a variety of services, such as:

- Expanding patient access to urgent care centers, after-hours care, and nurse help lines to give patients safe alternatives to emergency rooms for non-emergency care;
- Arranging for phone calls and, in some cases, in-home visits by nurses and other professionals to make sure that follow-up appointments are kept, medications are being taken safely, care plans are being followed, medical equipment is delivered, and home health care is being received;
- Offering intensive case management to help patients at high risk of hospitalization access the medical, behavioral health, and social services they need;
- Arranging for home visits by multidisciplinary teams of clinicians, who provide comprehensive care, teach patients and their caregivers how to take medications correctly, and link families with needed community resources; and

- Revamping physician payment incentives to promote care coordination and improved health outcomes.

The initial research demonstrates the success of these programs. A study¹⁶ published in the January 2012 edition of *Health Affairs* found that beneficiaries with diabetes in a Medicare Advantage special needs plan (SNP) had “seven percent more primary care physician office visits; nine percent lower hospital admission rates; 19 percent fewer hospital days; and 28 percent fewer hospital readmissions compared to patients in FFS Medicare.” These findings are reinforced by a series of studies, conducted by AHIP’s Center for Policy and Research, comparing patterns of care for enrollees in the Medicare Advantage program and the Medicare FFS program. One recent study¹⁷ found that after adjustments for readmission risk and disability entitlement status, the MA readmission rate was about 13 percent to 20 percent lower than that in Medicare’s traditional FFS program. An earlier study¹⁸ based on an analysis of hospital discharge datasets in five states estimated that risk-adjusted 30-day readmissions per patient with an admission ranged from 12-27 percent lower in MA than in Medicare FFS among patients with at least one admission.

Looking forward, both public programs and the private sector need to continue building upon this progress in order to create a health care system that is affordable for consumers and employers and sustainable in the long run. Meeting this challenge will require a system-wide commitment from all stakeholders to advancing delivery system reforms that improve patient care and payment reforms that reward physicians who deliver high quality and efficient care.

A new analysis,¹⁹ by researchers at the University of Southern California and AHIP, outlines the optimal role of the government to help accelerate delivery system reform. The authors suggest: (1) opportunities for joint public and private sector participation in payment reforms already underway; and (2) the opportunity for government to disseminate information on which payment models work, and for whom, creating a forum for broader awareness about the effectiveness of these payment and delivery system reforms.

¹⁶ Cohen, Robb, Jeff Lemieux, Jeff Schoenborn, and Teresa Mulligan. “Medicare Advantage Chronic Special Needs Plan Boosted Primary Care, Reduced Hospital Use Among Diabetes Patients.” *Health Affairs*. January 2012. Vol. 31, no. 1, p. 110-119.

¹⁷ Lemieux, Jeff, MA; Cary Sennett, MD; Ray Wang, MS; Teresa Mulligan, MHSA; and Jon Bumbaugh, MA. “Hospital Readmission Rates in Medicare Advantage Plans.” *American Journal of Managed Care*. February 2012. Vol. 18, no. 2, p. 96-104.

¹⁸ AHIP Center for Policy and Research. “Using AHRQ’s ‘Revisit’ Data to Estimate 30-Day Readmission Rates in Medicare Advantage and the Traditional Fee-for-Service Program.” October 2010.

¹⁹ Sood, Neeraj and Aparna Higgins. “Posing A Framework To Guide Government’s Role In Payment And Delivery System Reform.” *Health Affairs*. September 2012. Vol. 31, no. 9.

V. Conclusion

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