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June 21, 2010

Mr. Jim Hester, Director
Health Care Reform Commission
14-16 Baldwin Street
Montpelier, VT 05633

Via Email – jhester@leg.state.vt.us

Dear Jim;

We are pleased to submit this proposal to assist the Commission in developing a "Health Care System Design and Implementation Plan."

Please call if you have questions at (703) 269-5610. I will be out of the office after June 22, 2010 and will return by July 5, 2010. If you have questions during this period, please call Jeff Smith, Director of our State Practice at (703) 269-5538.

Sincerely;

John F. Sheils
Vice President
The Lewin Group

The Lewin Group®

HEALTH CARE AND HUMAN SERVICES POLICY, RESEARCH, AND CONSULTING—**WITH REAL-WORLD PERSPECTIVE.**

Health Care System Design and Implementation Plan for Vermont

Prepared for: The Vermont Health Care Reform Commission

Submitted by: The Lewin Group

Date: June 21, 2010

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Executive Summary

The Lewin Group is pleased to submit this proposal to design and analyze three options for creating a single state-wide system of health care that assures all Vermonters have affordable access to high quality health care services. We will develop these policy options based upon the principles and goals identified by the Vermont State Legislature in ACT 128. That bill calls for health reform options that assure universal access to essential health services for all Vermonters through a system that slows health care cost growth to sustainable levels.

Achieving universal health coverage will require moving beyond even the coverage expansion provisions and changes in health care financing recently enacted in the Patient Protection and Affordable Care Act (PPACA). Controlling costs while assuring access will also require bold payment system changes that reward providers for quality and efficiency. Vermont is uniquely positioned to reach these goals due to the flexibility of the state's Medicaid waiver and the emphasis on chronic care and medical homes under the state's existing Blueprint for Health program. The state has also laid the groundwork for a pilot study of "Accountable Care Organizations (ACOs)" designed to give providers new financial incentives for quality and efficiency.

We have assembled a multi-disciplinary project team that is uniquely qualified to perform this study. The project would be directed by Mr. John Sheils of the Lewin Group, who has specialized in analyses of the coverage and cost impacts of proposed health reform plans for nearly 25 years. He directed several studies for Vermont including a single-payer analysis and policy simulations for the "Hogan Commission." Mr. Sheils often assists members of Congress and other health policy leaders in designing health reform proposals, including the Wyden/Bennett health reform bill, which was ultimately endorsed by 16 Senators; half Democrat and half Republican.

Mr. Sheils directed several widely quoted studies of the impacts of the PPACA at various stages of the bill's progress through Congress. These include detailed modeling of the impact of the complex features and incentives created under the Act using the Health Benefits Simulation Model (HBSM) developed by the Lewin Group. In fact, the Lewin Group is the only non-government entity to issue a detailed study showing the financial impact of the PPACA on major stakeholder groups including the federal government, state and local governments, private employers, consumers, and health care providers.

Mr. Sheils is currently developing estimates of the PPACA effects on coverage and costs for each of the 50 states. He has also developed estimates of the impact of various delivery system reforms such as ACOs and bundled payment systems for the Commonwealth Fund "Bending the Curve" study and for the New York State Health Foundation. Our work with the PPACA enables us to minimize the cost of the financial analyses of policy options, thus enabling us to devote a much greater share of budget to program design, delivery system reforms and implementation plans.

We include three consultants as subject matter experts. These include Mr. Scott Wittman of Pacific Health Policy Group, who was heavily involved in designing the 1995 VHAP waiver, the Global Commitment waiver in 2006 and the Choices for Care waiver. Currently, Mr. Wittman is assisting the state with the extension of both Demonstrations and is reviewing the impact of

federal reform on existing eligibility groups and identifying opportunities for revising eligibility criteria. Mr. Whitman's intimate knowledge of the waiver and the Vermont health care system will be crucial to assessing the steps required to adapt the waiver to the three policy options selected for study.

Mr. Steven Lieberman M.Phil. will serve as a senior adviser in the development of payment systems for the three policy options. Mr. Lieberman is a Visiting Scholar at the Engelberg Center for Health Care Reform at the Brookings Institution, specializing in ACO development. He is currently co-editing a "user's manual" on ACO implementation, and is providing consulting support to five ACO pilot sites. He has health plan experience in payment system design and is a former Executive Associate Director with the Congressional Budget Office (CBO).

We also include Gerald Anderson Ph.D. to provide the international comparisons analyses called for in ACT 128. Dr. Anderson is a professor of international health at the Johns Hopkins School Public Health. He is the author of several publications comparing health care systems and describing the driving forces of change in other countries. He publishes an annual update on his international comparison research with the Commonwealth Fund. Dr. Anderson has also published extensively on payment system design and risk adjustment methodologies.

Mr. Sheils will be assisted by Lane Keonig Ph.D., a former Lewin Group employee who still works closely with us in our Virginia office on selected projects. He assisted Jim Hester of the Vermont Health Care Reform Commission in developing a feasibility study for ACO pilot programs to be implemented in Vermont, including interviews with providers, and identified other areas of inquiry for stakeholders. Dr. Keonig, who has extensive payment system expertise, will be responsible for stakeholder inquiries and will draft the delivery system options in consultation with Mr. Lieberman.

We also include Mr. Steven Kappel as our expert on Vermont data, who has held positions in the Joint Fiscal Office, the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) and Vermont Blue Cross/Blue Shield. We also include three Lewin Group experts in modeling and payment systems. These include: Randy Haught who is responsible for health reform modeling; Mr. Thomas Carlson, FSA, MAAA, a Lewin Group Actuary; and Peter Welch Ph.D. who has done extensive work on bundles payment methodologies.

Due to the multidisciplinary nature of the project team, careful management is important. We include Ms. Evelyn Murphy of the Lewin Group, who has superb management skills. She successfully managed similarly complex analyses of health reform options for Colorado, Mississippi and Alabama, as well as studies for several foundations and private organizations.

Vermont has a tradition of utilizing highly participatory processes in developing health policy. In keeping with this, we propose to work closely with staff from the Health Reform Commission and other Vermont agencies in designing the health reform models to be analyzed. We will also conduct work groups of insurers, providers and employer representatives to obtain their views and concerns with the options under development. The details of these processes and who is included will be developed in consultation with Commission staff.

We propose to conduct a series of design sessions in Vermont in which we would work through the key features of the options to be modeled. These meetings would include representatives of health agencies and stakeholder representatives where appropriate. Before each design session, we will prepare a summary of options and the design issues that must be addressed to analyze and a summary of the available options. We anticipate that the process will include Scott Wittman, Lane Keonig and John Sheils. We would extend that process to include Steven Lieberman when we meet to design the delivery system reforms.

After each design session, we will provide a summary of what was discussed including a description of items agreed to and those that still need to be resolved. This will help set the agenda for coming meetings. The final product will be a detailed description of each of the three policy options and any variations on these plans required in ACT 128.

We propose to work with the Health Reform Commission and other Vermont agencies in designing the health reform models to be analyzed. We will also conduct work groups of insurers, providers and employer representatives to obtain stakeholder group views and concerns with the options under development. The details of these processes and the specific groups to be included will be developed in consultation with Commission staff.

While the design process proceeds, we will adapt our models to use Vermont specific data as inputs, including the household survey data and health spending data provided by BISHCA. In particular, we would simulate the impact of the PPACA on coverage and costs for major stakeholder groups in the state, which will become our baseline analysis of what will happen under current law. This will include a summary of our estimated effects of the PPACA which we could present in the final report.

The models would be ready in time to simulate the health reform options developed in the design phase. We would then prepare a draft report for review and comment that describes the options modeled, presents our estimates of program costs, and presents an implementation plan for each option. Our analysis will include an assessment of potential savings under delivery system reforms and the cost control features of the proposal. Our goal is to provide a clearly defined roadmap for the next stage of health reform in Vermont.

I. Introduction

We present our response to the state's request for proposals (RFP) according to the format provided. Detailed resumes and examples of our analyses of health reform are presented in appendices. Our proposal is presented in the following sections:

- Understanding of Health Reform in Vermont;
- Background and Experience;
- Project Plan;
- Project Staffing;
- Data sets and Models;
- References; and
- Project Budget.

II. Understanding

Vermont has led the country in both coverage expansions and delivery system reforms. In 1989, Vermont established the Dr. Dynasaur program to expand coverage for children and pregnant women, which became part of the state-federal Medicaid program in 1992. When Congress created the Children's Health Insurance Program (CHIP) in 1997, the state further increased income eligibility for children to 300 percent of the FPL, which was well above eligibility levels adopted by most other states at the time.

Vermont obtained a Medicaid 1115a waiver in 1995 called the Vermont Health Access Program (VHAP). The waiver enabled the state to extend eligibility to all adults living below 150 percent of the FPL, including parents and non-disabled adults without custodial responsibilities for children. The program was designed to enroll most of the waiver population in managed care health plans. Eligibility was later raised to 185 percent of the FPL for parents. These are still among the highest income eligibility levels for adults in the Nation.

In 2005, Vermont negotiated a new Medicaid waiver called the "Global Commitment to Health." The waiver is designed to give Vermont greater flexibility in allocating its health resources to areas of greatest need. Under the waiver, the federal government committed to an aggregate five-year spending limit, based on agreed upon rates to account for both medical inflation and caseload growth. The state match is composed of state health spending under several departments. The Demonstration provides the opportunity to invest program savings in health-related programs, including health reform initiatives.

The waiver enables the state to shift resources across various departments and services without losing federal matching funds. Medicaid continues to serve major categories of eligible people including low-income individuals with special needs, but provides the opportunity to develop public-private partnerships and initiate payment reforms to improve Vermont's health care delivery system.

The state has taken advantage of the new flexibility provided by the waiver. Since 2006, the state has passed 10 separate bills that together have transformed Vermont into a laboratory for change in the delivery of care. The state created the "Blueprint for Health" initiative which is designed to reduce the health and economic impacts of common chronic health conditions. The program is designed to help providers operate as patient-centered medical home with the aid of multidisciplinary teams and expanded use of HIT.

The state has initiated the Blueprint Integrated Pilot Program (BPIPP) in several communities to demonstrate a multi insurer reform designed to promote health and improve quality. Key strategies include:

- Promote improvements in quality by providing bonus payments to providers based upon their performance against National Committee on Quality Assurance (NCQA) standards;
- Create Community Care Teams (CCTs) to support providers in providing community-wide health maintenance and prevention for the chronically ill;

- Include specialists in the CCTs public health prevention to assist in adopting community wide strategies for preventions;
- Support development of information technology such as a web based clinical tracking system (DocSite), electronic prescribing and electronic medical records; and
- Evaluation of impacts based upon NCQA scores, clinical process and health status measures and claims based data analysis of health care patterns and return on investment.

A remarkable aspect of the program is that the major commercial health plans in the state, including Blue Cross Blue Shield of Vermont and MVP, are participating in the program. The program compiles an evaluation of each medical practice based upon their performance against the NCQA guidelines for all of the patients they treat. These include those covered by Medicaid, Medicare and the commercial insurers. The insurers then provide bonus payments to providers based upon the quality score for each practice. This multi-payer approach focuses the attention on overall performance for all patients regardless of payer.

The state also created a new program to expand health insurance coverage called the Catamount Health Plan. The program is available to Vermont residents who have been uninsured for 12 or more months who are not eligible for Medicaid and do not have access to employer-sponsored insurance. The state subsidizes premiums for eligible people with incomes below 300 percent of the FPL. The benefits package includes a $250 in network deductible and $800 out of pocket spending limit. Payment levels under the plan are about 10 percent higher than Medicare provider rates, but less than typical commercial payment levels.

The state provides premium assistance to assist uninsured people in taking employer coverage when available. Subsidies are available to uninsured people living below 300 percent of the FPL who are not eligible for Medicaid. People are enrolled in Catamount Health if less costly than employer coverage.

In June of 2009, about 133,900 people were enrolled in the Vermont Medicaid program with another 3,300 enrolled in CHIP. About 25 percent of Vermont Medicaid beneficiaries were covered under a managed care health plan.

The State has implemented many other initiatives in recent years including:

- Improved outreach to the uninsured including marketing campaigns, enrollment tracking systems, and simplification of eligibility systems in public programs;
- Wellness promotion initiatives including food labeling, elimination of trans fats from commercial food products, healthy community and workplace programs and healthy lifestyle discounts for insurance;
- Enhanced Care for Chronic Conditions through the Blueprint multi-payer medical home pilot and the coordinated care management program (Office of Vermont Health Access (OVHA));
- Focus on quality improvement including "hospital report cards," consumer price and quality information systems, and expanded use of advance directives;

- Statewide Health Information Technology supported by the Health Information Technology Reinvestment fund, the electronic medical record pilot project and clinical tracking tools;
- Initiatives to increase the availability of providers including loan repayment and loan forgiveness programs for providers, standards for fair contracting, claims payment and prior authorization; and
- Continuation of older health resource planning programs such as Certificate of Need and the Health Resources Allocation Plan (HRAP).

The next innovation in delivery system reform for Vermont is a pilot program for an Accountable Care Organization (ACO). ACOs are a new form of delivery system network that enables hospitals and providers to organize to improve the quality and efficiency of care provided for a defined population. Under this system, physicians continue to bill payers for services on a fee-for-service basis, although some partial capitation could be developed. All of the physicians and hospital(s) included in the ACO would then receive annual bonus payments based upon performance against quality indicators and an estimate of the amount saved by the ACO through improved health and more efficient delivery of care.

The ACO changes provider incentives by allowing providers to share in the savings resulting from reduced health care costs. Under a typical FFS plan, the physician has an incentive to prescribe more and more services to enhance their incomes. Under the ACO, the provider is given a new incentive to minimize service use by improving quality and eliminating unnecessary utilization. It also creates an incentive to limit the acquisition of new capital, such as imaging equipment, because the steam of revenues for this new service will ultimately count against the ACO bonus.

The feasibility of the ACO model for a largely rural state like Vermont is greatly enhanced by the unique progress Vermont has made in forming multi-payer strategies under the Blueprint for Health. This enables the state to establish ACOs that encompass the entire population in a given area in a single "performance pool" to attain the critical mass required to reliably measure cost performance and to encourage the community care model introduced in the Blueprint.

The Patient Protection and Affordable Care Act (PPACA) recently signed into law by President Obama enables other states to catch up with Vermont in its commitment to affordable high-quality health care. The PPACA increases Medicaid eligibility levels for all adults to 133 percent of the FPL, which is still way below Vermont's Medicaid eligibility levels (185 percent of FPL for parents and 150 percent of the FPL for non-custodial adults). It also provides premium assistance tax credits for people through 400 percent of the FPL, which would encompass the existing Catamount eligibility group.

Federal funding for health care will increase under the Act. The Act increases federal matching percentage for all states by 23 percentage points and increases the federal match for adult expansion groups (i.e., parents above the "AFDC" income level and non-custodial adults) to 90 percent by 2019. Due to the flexibility of the Vermont waiver, there will be opportunities to use these new funds for other reforms to advance the state's long-term reform goals. The Act also approves ACOs for the Medicare program, which could dovetail nicely with the state's own ACO initiative.

The PPACA requires states to enforce new nationwide regulations of the insurance industry that have been in place in Vermont for many years. The Act requires guaranteed issue of coverage, prohibits premium variation with health status, and regulates insurer premiums subject to a minimum loss ratio requirement. Vermont already requires guaranteed issue and requires community rating of premiums in the individual and small group markets. However, the mandate for coverage under the Act could reduce premiums by adding the comparatively younger and healthier uninsured population to the individual market risk pool.

The centerpiece of the PPACA is the creation of state-level exchanges charged with presenting a selection of alternative competing health plans to individuals and small employers. However, it is unclear whether this will actually attract more commercial insurers to the state. The Act does select two new national health plans to be offered in every state exchange, which could introduce some added competition. The Act also provides $6.0 billion in funding for the creation of consumer owned cooperative insurance plans.

While the Act does advance the state of health reform in Vermont, the legislature has voted to obtain a study of options for the next stage of reform in the State. The PPACA permits states to adopt their own health reform model beginning in 2017. The legislature clearly envisions a single unified system of care that covers all Vermonters while using incentives and health spending budgets that will slow the growth in health care costs. The purpose of this study is to fully detail and analyze health reform options that meet these objectives.

III. Background and Experience

For this project The Lewin Group is partnering with the Pacific Health Policy Group (PHCG) to design health reform options for Vermont. We will build on the experience of both firms in the design and analysis of these options. Our background in these areas is presented below. However, we begin with a summary of our experience in designing systems that have expanded coverage and controlled costs.

A. Experience Designing Coverage Expansions and Containing Costs

ACT 128 requires that the contractor must "have demonstrated experience in designing health care systems that have expanded coverage and contained costs." The Lewin group and our subcontractor PHGC have participated in several design processes that have had these results. These are summarized below:

1. Experience Designing Systems that Have Expanded Coverage

Although the Lewin Group is known for its analyses of major health system proposals, a system-wide reform such as the PPACA is enacted by Congress only once in a generation. We were fortunate to be asked to provide analytic support for the Obama Administration's health reform effort. We also provided assistance to many members of Congress in understanding the bill and evaluating amendments. However, over the past 22 years, we have assisted the federal government and several states in designing incremental expansions in health insurance coverage that are still in operation today. Our experience includes:

- **Cost and Coverage under the PPACA:** For the Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services (DHHS), the Lewin Group developed estimates of eligibility and costs for health reform proposals that ultimately were endorsed by the Obama administration and became the PPACA. We have estimated that the Act will cover 30 million uninsured Americans. Analyses included estimation of eligibility and enrollment under alternative eligibility levels, and costs for the cost sharing subsidies provided under the bill. Estimated program costs under alternative methods for indexing eligibility and subsidy levels for cost and income growth over time.
- **Trade Adjustment Assistance Act Health Insurance Tax Credits:** The Lewin group was engaged by the U.S. Department of the Treasury to design the eligibility and enrollment systems to implement the tax credit for health insurance benefits created by Congress to assist individuals determine to be adversely affected by international trade legislation. The study involved identifying each of the various types of transactions that would need to be processed for beneficiaries to apply for and obtain benefits and designing a system to process these transactions. Lewin designed a system to exploit electronic payment systems to merge beneficiary contributions with federal subsidy payments so that payments are made only when the beneficiary pays their portion of the premium. The system was ultimately implemented according to the Lewin proposal within six months.
- **Design State Children's Health Insurance Plans (CHIP):** The Lewin group worked with several states to design and revise their CHIP programs including the District of Columbia and Indiana. This involved analysis of the number of children who would be

eligible and enrolled under the program at various income eligibility levels. We also estimate costs for CHIP programs run through Medicaid or benchmark health plans through an independent program. Estimates were used to final legislation.

- **Assist in Waiver Design:** Scott Wittman of PHPG assisted in the design of the original VHAP waiver in 1995. The waiver greatly expanded coverage for adults in Vermont. This included an increase in the income eligibility level to 150 percent of the FPL and for both parents and noncustodial adults (latter expanded to 185 percent of the FPL for parents). The waiver was designed to save money for currently eligible people with a program of managed care that was used to pay for the expansion. PHPG again assisted the Vermont Medicaid program in designing the Global Commitment to Health and Choices for Care Waivers.

2. *Experience with Cost Containment*

The Lewin Group and PHPG have developed several programs to control costs that continue in operation today. Much of this has been in the form of designing waivers to Medicaid rules that permit the state to reduce costs for the currently eligible population so that savings can be used to pay for expansions in coverage. Notably, Scott Wittman of PHPG has designed three waivers for Vermont that include savings through cost-saving managed care models. Our experience includes:

- **Design Global Commitment to Health and Choices for Care Waivers**: PHPG assisted the Vermont Medicaid program in designing the Global Commitment to Health and Choices for Care Waivers, which have given rise to several initiatives to improve quality while reducing costs. PHPG assisted Vermont with all facets of each program's development, including waiver drafting, public outreach, inter-departmental coordination, and negotiations with the Centers for Medicare and Medicaid Services (CMS). PHPG assisted Vermont with all facets of each program's development, including waiver drafting, public outreach, inter-departmental coordination, and negotiations with the Centers for Medicare and Medicaid Services (CMS).

- **Missouri Medicaid Efficiency Review:** For the State of Missouri, Lewin conducted a comprehensive review of the Medicaid program with recommendations on how the State can achieve short-term Medicaid savings, conduced detailed assessments on achieving longer-term program savings, and evaluated options to improve the effectiveness and efficiency of the Medicaid program. Lewin's analyses were used by State policymakers to craft the state fiscal year 2011 budget as well as guide decisions about future Medicaid program design and operations. Lewin's final report provided a series of recommendations regarding the structure and operation of the program, performance metrics to guide program management, and proposed approaches and priorities for enhancing the quality and efficiency of care to advance value-based purchasing and care coordination.

- **Medicaid Cost Containment Consulting:** For the Central Indiana Corporate Partnership (CICP), a private interest group composed of leading private businesses, commissioned The Lewin Group to conduct a major analysis of the State's Medicaid program with respect to Medicaid cost containment efforts including an inventory of current cost

containment efforts already underway and to provide suggestions for future cost containment strategies Indiana could consider, based on Lewin's experience and expertise in Medicaid cost containment. Lewin conducted these analyses and will present the findings in legislative testimony. Lewin assessed a wide range of potential cost-containment initiatives including revenue maximization, eligibility changes, preferred drug list initiatives, etc. Lewin also developed cost estimates for a prospective long-term care policy change that would eliminate existing wait-list and spend-down requirements for the state's home and community-based waiver program.

- **Washington State Legislature, Independent Review of Cost Containment Strategies**: For the Washington State Legislature, The Lewin Group analyzed Washington Medicaid cost containment efforts for the State Legislature and Governor's Office of Financial Management. Lewin inventoried cost containment efforts already underway, independently evaluated cost savings estimates produced by the State Medicaid agency, and recommended future cost containment strategies Washington could consider. Lewin presented our findings in three days of testimony to the State Legislature.

- **Arizona Medicaid Benefits Reduction Analyses:** The Lewin Group worked closely with the Arizona Health Care Cost Containment System (AHCCCS) Benefits Committee to identify ways to obtain Medicaid cost savings while causing the least possible harm to the covered beneficiary population and to develop estimates of the fiscal savings each benefits reduction option would yield. Lewin then analyzed claims and encounter data to inform the Committee on the number of persons using each service and the distribution of users by volume and costs, developing both "gross cost savings" estimates for each potential reduction as well as "net savings" estimates after considering the degree to which other covered services would be used in lieu of the service being eliminated or restricted.

B. The Lewin Group

The Lewin Group is a firm of 140 health care professionals consulting is a broad range of health policy issue areas for governments, providers, health plans and foundations. For the past 25 years, The Lewin Group has specialized in the design and analysis of complex reforms of both the health care financing system and the delivery system. The firm is widely considered to be one of the few independent sources of non-partisan analyses of the financial impacts of public coverage expansions and other health reform initiatives.

The Lewin Group was acquired by Ingenix Inc. in 2008 after 38 years of health care consulting. Ingenix is a wholly owned subsidiary of UnitedHealth Group Incorporated. UnitedHealth Group is a diversified health and well-being company dedicated to making the health care system work better. In addition to Ingenix, the UnitedHealth Group family of businesses includes United HealthCare, Ovations, AmeriChoice, Uniprise, OptumHealth and Prescription Solutions. In keeping with its tradition of non-partisan analysis, The Lewin Group does not advocate for any policy, program or legislation.

The Lewin Group has complete editorial control of its work products and our client work is not reviewed by Ingenix or United HealthGroup. The Lewin Group does not believe that any conflict of interest exists in connection with its ability to provide the consulting services for this

project since it does not involve the evaluation of any of its affiliates. For this project, The Lewin Group's task will be to assess the plan design alternatives specified by the Vermont legislature and to make a recommendation as to the alternative that would best meets Vermont's stated goals and objectives.

The Lewin Group was acquired by Ingenix Inc., a UnitedHealth Group company, in 2008 after 38 years of health care consulting. In keeping with its tradition of non-partisan analysis, The Lewin Group does not advocate for or against legislation. Lewin has complete editorial control of its work products and our client work is not reviewed by either parent company. For this project, Lewin's task will be to assess the plan design alternatives specified by the Vermont legislature and to make a recommendation as to the alternative that would best meet Vermont's stated goals and objectives.

The Lewin Group recently conducted a series of analyses of Patient Protection and Affordable Health Choices Act (PPACA) as it moved through Congress. The Lewin Group is the only entity outside government that conducted a comprehensive analysis of the Act on coverage, federal and state, providers, employers and consumers. The executive summary of our report on the Act as finally passed is presented in ***Appendix B.***

The Lewin Group has also performed several studies on the impact of reforms of the health care delivery system and their likely impact on health care costs. These include analyses of bundled payment, comparative effectiveness research and ACO like systems. In fact, The Lewin Group provided the estimates for the original "Bending the Curve" analysis developed for the Commonwealth Fund.

We present examples of four categories of work below:

- Studies of health reform in Vermont;
- Financial analyses of PPACA and other Congressional legislation;
- Experience designing health reform legislation; and
- Analyses of health reform in other states.

1. Studies of Health Reform in Vermont

The Lewin Group has conducted several studies of health reform proposals for Vermont. These include:

- **State Planning Grant Support:** In 2001, The Lewin Group assisted a state appointed commission in evaluating the need for reform and analyzed the impact of eight policy options. The study included a series of interviews, work groups and focus groups of representatives of major stakeholder groups that were used to help shape the policy options. The study was conducted under a HRSA State Planning Grant;
- **Single-payer Analysis for Vermont:** For the HRSA State Planning Grant project in 2001, The Lewin Group analyzed the cost impact of implementing a single-payer system for Vermont including the impact on total health spending, necessary financing and changes in spending for key stakeholder groups;

- **VHAP Buy-in proposal:** For the "Hogan Commission," we analyzed the impact of alternative approaches to a VHAP buy-in program;
- **A Voucher Program for VHAP and CHIP enrollees:** In 2002, Lewin developed an analysis of the cost impacts of covering VHAP and CHIP enrollees under a voucher program for the Office of Vermont Health Access (OVHA); and
- **Buy-in Proposal:** For OVHA, we estimated the cost and coverage impacts of a VHAP buy-in program for individuals and small employers in 2004.

2. *Financial Analyses of PPACA and Other Congressional Legislation*

The Lewin Group has provided analyses of the cost and coverage impacts of major national health reform initiatives. We have developed and repeatedly updated a large micro-simulation model of the U.S. health care system that is designed to estimate the impact of major changes in the health care system on major stakeholder groups at the state and national levels. Example projects include:

- **Cost and Coverage under PPACA:** Estimated the cost and coverage impacts of the PPACA signed into law by President Obama. Included analysis of state and local government spending; private employer costs by firm size, industry, and current insuring status; family health spending by demographic group; and health care providers. The study featured long term impacts estimates through 2029;
- **Earlier Congressional Versions of PPACA:** Comparative analysis of the cost and coverage impacts of the House and Senate health reform bills for the Peterson Foundation. Included analyses of the legislation's impact on: federal health spending and revenues and for other stakeholder groups including employers, families, state and local governments and providers; included analysis of the public plan under the proposal and spending levels under the plan;
- **Presidential Health Plan Comparison:** Developed a comparison of the 2008 Presidential candidate's health reform proposals on coverage and costs for the federal government and major stakeholder groups. Included estimation of the impact of a "Public Plan" modeled on Medicare, Medicaid expansions, premium subsidy tax credits, high-risk pool proposals and simulation of proposed underwriting rules for the individual and small group insurance markets.
- **Tax Credit Proposals:** For the Office of The Assistant Secretary for Planning and Evaluation (ASPE), DHHS, developed estimates of the cost and coverage impacts of proposals to expand health insurance coverage including President Bush's tax deduction proposal and the Congressional Tax Credit Plan. Included estimation of changes in coverage, federal tax revenues and other stakeholder impacts.
- **Comparison of Ten Congressional Health Reform Bills:** Compared the impact of the coverage provisions of ten congressional proposals to reform the U.S. health care system. These included bills that would expand Medicaid eligibility, eliminate waiting period for Medicare disabled, create a public plan modeled on Medicare, a Medicare buy-in for people age 55 to 64, Medicare for all single-payer models and replacing the tax exclusion for employer health benefits with a tax credit for private insurance.

3. *Experience Designing Health Reform Legislation*

The Lewin Group has assisted legislators and private associations in designing health reform proposals that achieve their health reform goals.

- **Congressional Legislation:** Assisted U.S. Senators Wyden and Bennett in developing a bi-partisan proposal to reform the U.S. health care system that would cover all Americans not covered under Medicare (including Medicaid) under a system of competing private health plans, including people now eligible for Medicaid. The bill ultimately had 16 sponsors in the U.S. Senate including 8 Democrats and 8 Republicans;
- **Children's Coverage:** Developed a proposal to provide coverage to all children for the Children's Defense Fund (CDF). Included a mandate for all children to have coverage, expansions in SCHIP eligibility and provisions designed to increase enrollment levels among eligible children including: "Express-Lane" enrollment of children in other means tested programs (i.e., food stamps, WIC, and school lunch programs), 12-month certification, self-declaration of income for children's coverage and elimination of SCHIP premiums and co-payments.
- **Hospital Association Plan**: Assisted the Federation of American Hospitals (FAH) in developing their recent proposal to reform the U.S. health system. Included analysis of the plan's impact on coverage, and costs for major stakeholder groups including the federal government, state and local governments, employers and consumers. Included detailed analyses of the plan's impact on provider revenues.

4. *Cost Control and Delivery System Reform*

Most of the policy options modeled by Lewin include changes in the delivery system that are designed to reduce cost growth by changing consumer and provider incentives. In these analyses, we have developed models of the likely effects of these provisions on costs based upon evaluations of pilot programs and Medicare demonstrations.

- **The "Bending the Curve" Study:** For the Commonwealth Fund, we developed estimates of the savings that could be achieved by adopting several changes to the health care financing and delivery system. These included an analysis of changes in payment methodologies designed to create new provider incentives to improve quality while reducing costs as well as an analysis of public health initiatives, funding for health information technology (HIT) and comparative effectiveness research.
- **Options for slowing cost growth in New York:** For the New York State Health Foundation we are analyzing 10 options for reducing health spending in New York. These options include ACOs, medical home programs, bundled payment systems, administrative simplification, increased use of palliative care, waiver options for long-term care and managed care programs for the dual eligible population.
- **Comparative Effectiveness Savings**: For Pfizer Inc., we developed an analysis of the potential impact of proposals to create a federal program to fund research on the comparative effectiveness of alternative health treatments. Included an assessment of medical practice variation, adherence to evidence-based medical (EBM) guidelines and

approaches to increase physician compliance with EBM. Included an analysis of how coupling EBM research with strong financial incentives for adherence affects likely net savings.

- **Universal Coverage with Delivery System Reform:** The Lewin Group developed an analysis of the Commonwealth Fund's health reform proposal presented in "The Path to a High Performance U.S. Health System." This study combined our analyses of savings from delivery system reforms with the universal coverage proposal introduced by the Commonwealth Fund.

5. Other State Health Reform Legislation

The Lewin Group has assisted several states in evaluating the impact of alternative health reform plans for legislative commissions and other state agencies. The cost and coverage analyses we provided were developed using a version of The Lewin Group model that is built upon state-specific data. Examples of our state level work include:

- **Design and Analyze Health Reform Options for Colorado:** Lewin analyzed several options for achieving universal coverage in Colorado in support of a governor appointed commission of public and private stakeholders (i.e., the "208 Commission"). We worked with the authors of four different universal coverage proposals to refine and analyze their impacts. These included a single-payer proposal, Medicaid expansions, employer contribution proposals and health insurance market reforms. This resulted in recommendations and a report describing the key features and impacts of these proposals. The Governor has implemented several of the Commission's recommendations.
- **Evaluate a Single-payer Program for Hawaii**: Evaluated the impact of a single-payer program for the state of Hawaii. The study emphasized a balanced and non-partisan evaluation of the advantages and disadvantages of adopting such a program. It also included a detailed analysis of health spending in the state and the financial impact of the proposal on major stakeholder groups.
- **Achieving Universal Coverage in New York:** For the United Hospital Fund, Lewin developed an analysis of several options for expanding insurance coverage in New York State, including mandatory and voluntary approaches to expanding coverage. These included variations on the "Pay-or-Play" model where employers are required to either provide insurance or pay a tax. We also looked at methods to expand coverage in the state through public programs only, such as Medicaid expansions and tax credits. Lewin also developed a detailed accounting of all public and private health spending in the state.
- **Health Reform Legislation in Wisconsin:** Estimated the cost and coverage impacts of proposed legislation in Wisconsin that would cover all workers and their families under a program emphasizing a combination of health savings accounts (HSAs) and managed competition to control costs. The client was a consortium of the Wisconsin Health Project, state legislators, the AFL-CIO, and other stakeholder groups in Wisconsin. The bill was ultimately adopted by the state Senate.

C. The Pacific Health Policy Group

The Pacific Health Policy Group (PHPG) is a national consulting firm that specializes in providing planning, operational, and oversight assistance for public health care programs. PHPG has worked for a number of states to develop and implement health care system designs and initiatives to best serve the needs of residents while maintaining compliance with federal requirements and working within fiscal budgetary constraints.

PHPG designed and helped Vermont to implement two groundbreaking Section 1115 waivers – *Global Commitment to Health* and *Choices for Care*– under which Vermont was granted extraordinary financial and programmatic flexibility to help maintain its broad public health care coverage and provide more effective services. PHPG's experience in Vermont and other states relevant to this project are described below.

1. *State of Vermont*

Our consultants have significant experience with the development of innovative health reform programs, particularly within the state of Vermont. Since 1994, PHPG has served as a primary consultant to the Vermont Legislature and Medicaid. Over the last sixteen years, PHPG has assisted Vermont with a broad array of policy analyses, program development, and implementation activities. Projects for Vermont include:

- **Assist in VHAP Waiver Design:** PHPG was originally retained by the state to assist with the development and implementation of the Section 1115 managed care waiver Vermont Health Access Plan (VHAP). As Vermont's first demonstration program, VHAP included the transition from fee-for-service to managed care and a significant expansion of eligibility. PHPG drafted the original operational protocol for VHAP and outlined how eligibility for the program would be verified and tracked. We also performed several independent evaluations of the VHAP waiver, assessing its performance with respect to service accessibility, quality of care, and cost effectiveness.
- **Design Global Commitment to Health and Choices for Care Waivers**: PHPG assisted Vermont with all facets of each program's development, including waiver drafting, public outreach, inter-departmental coordination, and negotiations with the Centers for Medicare and Medicaid Services (CMS). PHPG's implementation assistance included:
  - Transforming Vermont's Medicaid office to a public managed care model under the Global Commitment to Health Waiver;
  - Drafting inter-governmental agreements;
  - Development of actuarial datasets;
  - Facilitation and coordination of the rate setting process;
  - Development of the program evaluation plan; and
  - Coordination of financial transactions and reporting across departments.
- **Ongoing Waiver Support:** PHPG has provided Vermont with ongoing assistance throughout the course of the Global Commitment to Health and Choices for Care Demonstrations, including evaluation and waiver amendment and renewal processes.

Currently, PHPG is reviewing the impact of federal reform on existing eligibility groups and identifying opportunities for revising eligibility criteria.

- **Other Projects:** During the past five years, PHPG also has provided assistance to Vermont with the following:
  - Performing audit and report eligibility findings for both the Medicaid program and Children's Health Insurance Program for the FY 2007 and 2010 Payment Error Rate Measurement (PERM) audit process;
  - Development of annual Medicaid budgets and enrollment estimates;
  - Development of long-term budget forecasts (up to ten years);
  - Development of cost containment strategies for hospital, physician, pharmacy, and dental services;
  - Development and implementation of contract monitoring functions;
  - Development of performance-based contracts;
  - Assistance with procurement for correctional health services;
  - Development of innovative programs for behavioral health services;
  - Assistance with evaluation of legislative initiatives;
  - Development of position papers on behalf of the Governor's office; and
  - Presentations in public forums and legislative hearings.

2. Health Reform in Other States

PHPG has assisted several states in designing their Medicaid programs. Projects include:

- **Managed Care Systems for Florida:** The Florida House of Representatives retained PHPG in January 2010 to provide information on alternative managed care systems and successful models in other states that may have application for reform of Florida's Medicaid program. PHPG summarized current challenges facing the Florida Medicaid program and the important elements of the program and health care delivery system.
- **Options for Program Reform in Florida:** In March 2010, PHPG consultants presented options for program reform to the Florida House of Representatives. Options for reform included incremental expansion of Florida's current Medicaid managed care pilot; implementation of medical homes; movement towards statewide implementation of capitated managed care; and use of managed long-term care. Each option was considered in terms of its potential impact on cost, access, quality, and other focus areas.
- **Study of Medicaid Cost and Quality in Alaska:** PHPG was retained by the Alaska State Senate Legislative Affairs Agency in 2006 to conduct a comprehensive study of the cost and quality of the Alaska Medicaid program. Our work was a follow-up to a study commissioned by Alaska Medicaid in 2005 that contained high-level findings on program expenditure growth suggesting the state could confront a fiscal crisis in the next decade due to changing demographics. Our final report presented a series of initiatives for reforming Alaska's program and slowing the rate of growth in expenditures while improving access to services, particularly for the Medicaid program's large Native Alaskan beneficiary population.

- **Medicaid Reform in Alaska:** PHPG is continuing to assist Alaska in reforming its Medicaid program. We recently were retained to evaluate opportunities to enhance federal Medicaid funding for Alaska behavioral health and substance abuse treatment services. The study includes an evaluation of the current program structure and service gaps.
- **Managed care Procurement in Arizona:** PHPG assisted in designing and updating the competitive procurement process for the Arizona Health Care Cost Containment System (AHCCCS) and has participated in every managed care procurement process since 1994. We also advise Arizona on other program components including managed care contractor oversight and Medicaid eligibility. We are currently overseeing a redesign of the clinical eligibility criteria for children with developmental disabilities.

IV. Project Plan

ACT 128 requires the contractor to develop and analyze three design options for creating a single system of health care for all Vermonters. These include fully designed health care financing systems with implementation plans and analyses of their financial impacts. For each of these options, the contractor is required to analyze the impact of three to four separate benefits packages in terms of covered services and patient cost-sharing. The contractor is also required to evaluate alternative payment systems and provide a plan for integrating existing health initiatives into each proposal.

We propose a participatory process for designing and evaluating policy options. We propose to conduct design sessions that bring together Commission staff with subject matter experts to develop options suited to the unique features of the state. To assure that the design options dovetail with existing health initiatives, we propose to include representatives of other relevant agencies such as BISCHA, OVHA and the Blueprint for Health. We also propose to conduct work groups and interviews with key stakeholder representatives in the state that will be used to inform the design process.

Throughout the design process we will provide data analyses and financial modeling to assist in evaluating the impact of alternative design elements. We would provide estimates of the cost and coverage impacts of alternative design options as the specifications of the plan are developed. We will also include actuarial analyses in support of the benefits design process. In addition, we would provide estimates of the impact of alternative financing mechanisms on employers and consumers in various age and income groups.

In this section, we describe how we would execute the various steps of the study. We begin by presenting an overview of our management plan and then explain how we will address the requirements specified in Section 6, paragraphs (d) and (e) of ACT 128. We conclude with a detailed description of project tasks and milestones and the corresponding timeline.

A. Management Plan

We have formed an interdisciplinary team that provides the breadth of expertise required to design and analyze implementable health reforms that incorporates state-of-the-art thinking on provider reimbursement methodologies. We include three subject matter consultants including Scott Wittman of PHBG, Steve Lieberman of the Brookings Institution, Gerald Anderson of Johns Hopkins University, and Steve Kappel of Policy Integrity in Vermont.

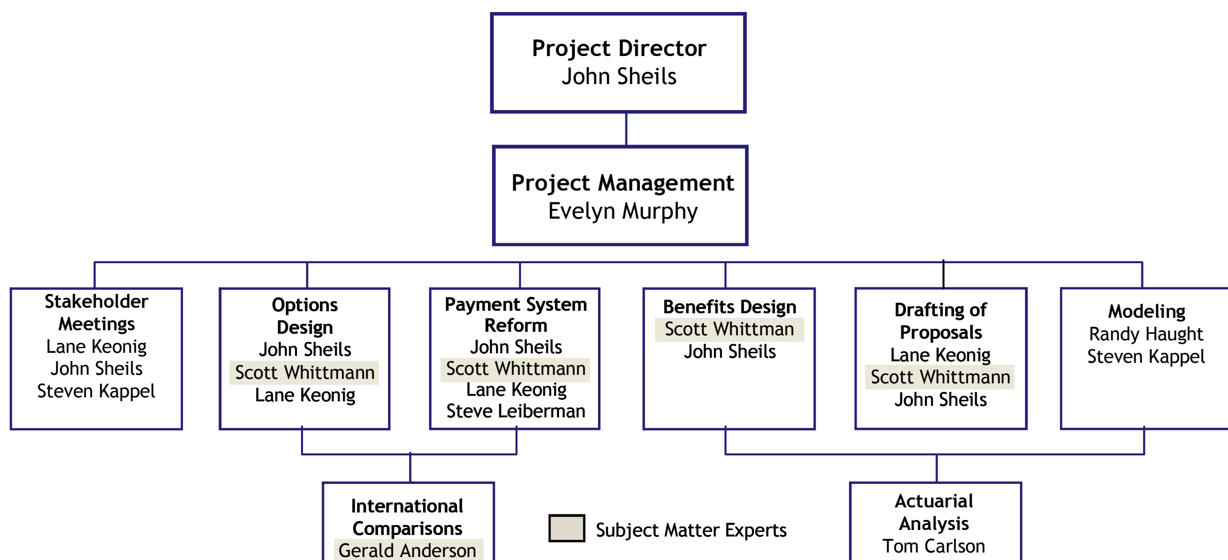
John Sheils, a Lewin Group Vice-president, will be project director ***(Figure 1)***. He would be assisted by Ms. Evelyn Murphy who will be responsible for day-to-day management of the project. This will include arranging meetings and work group sessions, making sure that meeting materials and deliverables are completed on time, oversight of contract and subcontractor materials, and quality control functions.

John Sheils will work with Lane Keonig Ph.D. and Steve Kappel to conduct work group meetings with key stakeholder groups. The purpose is to obtain input and feedback on the options developed over the course of the project from physicians, hospitals employees and insurers. This will build upon some of the ground work Lane Keonig did in his provider

surveys for the Vermont ACO feasibility study projects. We also propose to include Steve Kappel in this process because of his familiarity with stakeholders in the Vermont health care system.

Scott Wittman and Lane Keonig will participate in designing the three coverage options and various financing methods. As discussed above, this will take the form of a number options design meetings with Commission staff and representatives of other state agencies as appropriate. Steve Lieberman will be included in the design sessions where provider payment systems and reforms are discussed. John Sheils and Steve Wittman will participate in the benefits design process with the assistance of Tom Carlson, FSA, MAAA, who is a Lewin Group actuary.

Figure 1
Organization of The Lewin Group Project Team



Randy Haught of The Lewin Group will be responsible for all modeling of the health reform options using the models and data discussed below. We also include Peter Welch Ph.D. of The Lewin Group who is widely published on Medicare payment systems. Steve Kappel would assist in identifying the Vermont-specific data required to model the effects of some of these options.

We will hold a regularly scheduled telephone conference with Commission staff on a weekly basis. The Lewin Project team will also meet in a second regularly scheduled weekly basis to review progress on the project.

B. Single System Design Option

(d) Each design option shall propose a single system of health care which maximizes the federal funds to support the system and is composed of the following components, which are described in subsection (e) of this section:

(1) a payment system for health services which includes one or more packages of health services providing for the integration of physical and mental health; budgets, payment methods, and a process for determining payment amounts; and cost reduction and containment mechanisms;

(2) coordinated regional delivery systems;

(3) health system planning, regulation, and public health;

(4) financing and estimated costs, including federal financings; and

(5) a method to address compliance of the proposed design option or options with federal law.

We will develop three health system reform options that meet the legislature's specification of a "single system" that provides affordable high-quality care to all Vermonters. The legislation specifies that one of these options must be a single-payer system while the second would be a public plan option model. We will also develop a third option that meets the goals and principles specified in sections 2 and 3 of ACT 128.

While the bill identifies two broadly defined options, it will be up to the consultant to specify the details of these options with the guidance of Commission staff. We will need to define the following features of each option:

- Universe of covered individuals, which we assume includes all Vermonters including those enrolled in Medicare;
- Coverage of undocumented immigrants;
- Covered services;
- Patient cost sharing;
- Provider payment levels and payment systems;
- Form of provider payment;
- Delivery system reforms;
- Financing mechanisms (Current public funding, premiums, payroll taxes, income taxes and consumer taxes);
- Required changes to the Medicaid waiver; and
- Other required changes in federal law (Medicare waiver, Changes to ERISA).

In particular, we will explore the use of budgets as a means of managing capital acquisition or limiting health spending. For example, ACO-like entities could be developed throughout the state that would be required to meet enrollee health care needs within a fixed budget.

We will draw upon our long experience in developing detailed specifications of health reform plans, usually through participatory processes. Prior to each design session, we will prepare a summary of potential design parameters for each of the three options. We will provide these materials to design group participants in advance of each session. These ideas would be discussed and revised in each design session. We would then write-up the specifications that were selected and circulate it to design session participants for approval.

It will be important to consider in these design sessions how the health reform options would dovetail with existing health initiatives in the state. These include health system planning, public health and efforts to coordinate regional systems as under the Blue Print and the ACO pilot project. This is perhaps best accomplished by including staff from the relevant government initiatives in the design sessions.

C. Payment System for Health Services

1. Benefits Packages

> (1) A payment system for health services.
>
> (A) (i) Packages of health services. In order to allow the general assembly a choice among varied packages of health services in each design option, the consultant shall provide at least two packages of health services providing for the integration of physical and mental health as further described in subdivision (A)(ii) of this subdivision (1) as part of each design option.
>
> (ii) (I) Each design option shall include one package of health services which includes access to and coverage for primary care, preventive care, chronic care, acute episodic care, palliative care, hospice care, hospital services, prescription drugs, and mental health and substance abuse services.
>
> (II) For each design option, the consultant shall consider including at least one additional package of health services, which includes the services described in subdivision (A)(ii)(I) of this subdivision (1) and coverage for supplemental health services, such as home- and community-based services, services in nursing homes, payment for transportation related to health services, or dental, hearing, or vision services.
>
> (iii) (I) For each proposed package of health services, the consultant shall consider including a cost-sharing proposal that may provide a waiver of any deductible and other cost-sharing payments for chronic care for individuals participating in chronic care management and for preventive care.
>
> (II)For each proposed package of health services, the consultant shall consider including a proposal that has no cost-sharing. If this proposal is included, the consultant shall provide the cost differential between subdivision (A)(iii)(I) of this subdivision (1) and this subdivision (II).

This section of ACT 128 requires the consultant to include in the study at least two alternative benefits packages for each of the three system-reform design options discussed above. We propose to identify the details of these benefits packages though the design sessions. We will prepare alternative benefits designs for discussion in the designated design session. The Lewin Group actuary for this project (Tom Carlson) will provide actuarial estimates of the cost of these benefits option for Vermont residents.

The bill provides guidance on the items to be included in these benefits packages. The first benefits package must include primary care, preventive care, chronic care, acute episodic care, palliative care, hospice care, hospital services, prescription drugs, and mental health and substance abuse services. The second benefits package will include supplemental services such as home- and community-based services, services in nursing homes, payment for transportation related to health services, or dental, hearing, or vision services. Both packages would provide parity for coverage of physical and mental health services.

The law also requires the contractor to evaluate these benefits packages under alternative patient cost-sharing requirements. Cost sharing is an important design element because it determines the amount of covered benefits to be reimbursed under the design option. Also, patient cost sharing amounts can affect the level of health services utilization, which also drives system costs. Studies have shown that the rate of health services utilization increases as cost sharing is reduced.

We will specify deductibles and co-payment amounts for the first benefits package in consultation with Commission staff. As specified in the legislation, there would be no cost-sharing for chronic care for individuals participating in chronic care management and for preventive care. In addition, the bill requires the consultant to consider a design option that covers the required services with no patient cost sharing.

Our proposed actuary will provide estimates of the per-member-per-month (PMPM) costs of the alternative benefits and cost-sharing packages to be used in evaluating the options with Commission staff. These estimates will reflect the impact that cost sharing has on the overall level of spending.

We will also consider the impact of covered services and cost-sharing on other program administrative costs. For example, while cost sharing reduces utilization, it requires the state to maintain a program that helps low income people who can not afford to pay the copayments. However, no such program is required if patient copayments are not required. We would include analyses of this trade-off as we evaluate the impacts of the programs.

2. Administration

(B) Administration. The consultant shall include a recommendation for:

(i) a method for administering payment for health services, which may include administration by a government agency, under an open bidding process soliciting bids from insurance carriers or third-party administrators, through private insurers, or a combination.

(ii) enrollment processes.

(iii) integration of the pharmacy best practices and cost control program established by 33 V.S.A. §§ 1996 and 1998 and other mechanisms to promote evidence-based prescribing, clinical efficacy, and cost-containment, such as a single statewide preferred drug list, prescriber education, or utilization reviews.

(iv) appeals processes for decisions made by entities or agencies administering coverage for health services.

In this section we will identify alternative approaches to administering the program. As described in the legislation, we would consider a design where the state contracts for program operations including claims processing and utilization review. We would also identify approaches for enrolling people in the program.

In a single state-wide system of care, enrollment would be automatic for all residents, except to the extent that the undocumented are excluded from the program. Vermonter's can be identified at birth or as they move to the state. Residents would remain eligible until they leave

the state or die. This is a far less costly system to administer than our current system of multiple payers, where coverage varies as people move between jobs and as their eligibility for public programs changes over-time.

These design features have huge implications for the cost of administering these programs. In this study, we would quantify the amounts saved by going to a single-system with simplified enrollment and a uniform benefits package, including claims administration. Some of the proposed approaches for putting hospitals under a single unified budget actually eliminate claims filing and patient accounting altogether (i.e., as in Canada), resulting in further savings. We will quantify these administrative savings based upon recent studies of the cost of administering health insurance, including administrative costs for insurers and public programs, and hospital and physician costs for interacting with health plans. The items we would estimate include:

- Reduced cost for administration of public programs;
- Reductions in commercial insurer administrative costs including insurance brokers fees etc.;
- Simplified claims filing costs for hospitals; and
- Savings to physicians from standardized eligibility, service authorization and claims filing processes.

In this study we will quantify the administrative savings attributed to each of these features of the design options.

3. Establishing Health Spending Budgets

(C) Budgets and payments. Each design shall include a recommendation for budgets, payment methods, and a process for determining payment amounts. Payment methods for mental health services shall be consistent with mental health parity. The consultant shall consider:

(i) amendments necessary to current law on the unified health care budget, including consideration of cost-containment mechanisms or targets, anticipated revenues available to support the expenditures, and other appropriate considerations, in order to establish a statewide spending target within which costs are controlled, resources directed, and quality and access assured.

(ii) how to align the unified health care budget with the health resource allocation plan under 18 V.S.A. § 9405; the hospital budget review process under 18 V.S.A. § 9456; and the proposed global budgets and payments, if applicable and recommended in a design option.

(iii) recommending a global budget where it is appropriate to ensure cost-containment by a health care facility, health care provider, a group of health care professionals, or a combination. Any recommendation shall include a process for developing a global budget, including circumstances under which an entity may seek an amendment of its budget, and any changes to the hospital budget process in 18 V.S.A. § 9456.

ACT 128 requires the study to consider the implementation of health spending budgets. Under a budgeted system, policy makers specify the total amount that can be spent on health care for all Vermont residents, and adapts the payment system so that these budgeted levels are not exceeded. For example, the state could determine that health spending can not be allowed to grow faster than the growth in Vermonter incomes as measured by the growth in state-wide

gross domestic product. While this simplistic reasoning has its appeal, it is arbitrary and does not consider the impact it would have on access and the acquisition of new medical technology.

The alternative is to implement a process for determining a budget for health spending that builds upon health needs assessments such as those developed in Vermont's Health Resources Allocation Plan (HRAP), the Certificate of Need (CON), and the Public Oversight Commission (POC). In addition, budgeting could be determined based upon the projected demographics of the population, changes in input costs and careful health needs assessments throughout the state.

In this project, we will assist Commission staff in defining a budgeting process for Vermont. We will review the methods for creating such a budget, which include building on existing initiatives in the state. We will also review the approaches used in other countries which have implemented a budget for at least a portion of their health spending.

We include Dr. Anderson of John Hopkins University who is an expert on international health care systems. He will participate in a design session devoted to this subject where he will provide background on the approaches used in other countries, including an evaluation of the consequences of these processes for quality and access to new technology.

The result will be a budgeting model designed to suit the unique health care system in Vermont and that builds upon existing oversight programs in the state. To support this process, we will prepare projections of health spending through the next ten years and estimate the amount that would be saved by adopting alternative budgets on spending over-time.

4. Conventional Payment Systems

> (iv) payment methods to be used for each health care sector which are aligned with the goals of this act and provide for cost-containment, provision of high quality, evidence-based health services in a coordinated setting, patient self-management, and healthy lifestyles. Payment methods may include:
>
> (I) periodic payments based on approved annual global budgets;
>
> (II) capitated payments;
>
> (III) incentive payments to health care professionals based on performance standards, which may include evidence-based standard physiological measures, or if the health condition cannot be measured in that manner, a process measure, such as the appropriate frequency of testing or appropriate prescribing of medications;
>
> (IV) fee supplements if necessary to encourage specialized health care professionals to offer a specific, necessary health service which is not available in a specific geographic region;
>
> (V) diagnosis-related groups;
>
> (VI) global payments based on a global budget, including whether the global payment should be population-based, cover specific line items, provide a mixture of a lump sum payment, diagnosis-related group (DRG) payments, incentive payments for participation in the Blueprint for Health, quality improvements, or other health care reform initiatives as defined in 3 V.S.A. § 2222a; and
>
> (VII) fee for service.

Once global budgets are determined, they must be enforced through some form of payment system. Thus the design of the payment system is crucial to the plan's effectiveness in constraining spending to budgeted levels. For example, the primary form of payment in today's health system is fee-for-service (FFS). This is a "piecework" payment system where providers are paid a set amount for each service they provide, regardless of health outcomes. This creates incentives for providers to prescribe more and more services that can be billed by the provider, even if the services are of little clinical value to the patient.

These FFS incentives can easily defeat attempts to control spending by cutting payment levels. For example, the Congress often cuts the growth in provider payment levels under Medicare in an attempt to reduce the federal deficit. However, it is widely documented that these reductions in payment levels are met with increases the number of services provided. For example, CMS has shown that 30 cents of every dollar of payment reductions is recovered through increases in service volume.

Various forms of "capitation" have been shown to improve efficiency and reduce costs. Capitation is where a provider or health plan accepts a fixed dollar amount (i.e., a capitation) to deliver a package of services, regardless of the amount of services the patient actually uses. These systems create strong incentives to improve efficiency and reduce health care costs. This has been shown to be true of Health Maintenance Organizations, which provide full coverage for individuals for a capitated amount, or diagnostic relate groups (DRGS), which are a capitatied payment to the hospital for each hospital stay by diagnosis.

As discussed below, we will explore alternative delivery systems that provide incentives for providers to deliver care efficiently such as bundled payments and ACOs. However, it is unlikely that we will ever fully eliminate all of these conventional payment methodologies. For example, even ACOs continue to pay providers on a FFS basis while focusing on the bonus potential to encourage efficiency. Also, it may take longer to develop delivery system reforms like ACOs in rural areas than in other parts of the state. This may require use of more conventional systems in some areas, at least in the near-term.

Thus, we will review existing payment systems for use in the various design options. These include the systems used by Medicare and the major commercial insurers in the state such as DRGs, DRGs for outpatient care and the Relative Benefit Relative Value System (RBRVS) physician payment systems. Several of our project team members have extensive experience in designing and using these conventional payment systems including Gerald Anderson Ph.D., Scott Wittman, Peter Welch Ph.D. and Randy Haught. We will also review efforts to use payment supplements to encourage providers to serve in underserved areas of the state.

In addition, we would review payment systems used in other countries for use in the Vermont design options. Dr. Anderson is one of the leading American researchers on international health care systems. He has studied these systems, including the reasoning behind their design and the problems countries are having with them.

5. *Innovative Payment Systems*

(v) what process or processes are appropriate for determining payment amounts with the intent to ensure reasonable payments to health care professionals and providers and to eliminate the shift of costs between the payers of health services by ensuring that the amount paid to health care professionals and providers is sufficient. Payment amounts should be in an amount which provides reasonable access to health services, provides sufficient uniform payment to health care professionals, and assists to create financial stability of health care professionals. Payment amounts shall be consistent with mental health parity. The consultant shall consider the following processes:

(I) Negotiations with hospitals, health care professionals, and groups of health care professionals;

(II) Establishing a global payment for health services provided by a particular hospital, health care provider, or group of professionals and providers. In recommending a process for determining a global payment, the consultant shall consider the interaction with a global budget and other information necessary to the determination of the appropriate payment, including all revenue received from other sources. The recommendation may include that the global payment be reflected as a specific line item in the annual budget.

(III) Negotiating a contract including payment methods and amounts with any out-of-state hospital or other health care provider that regularly treats a sufficient volume of Vermont residents, including contracting with out-of-state hospitals or health care providers for the provision of specialized health services that are not available locally to Vermonters.

(IV) Paying the amount charged for a medically necessary health service for which the individual received a referral or for an emergency health service customarily covered and received in an out-of-state hospital with which there is not an established contract;

(V) Developing a reference pricing system for nonemergency health services usually covered which are received in an out-of-state hospital or by a health care provider with which there is not a contract.

(VI) Utilizing one or more health care professional bargaining groups provided for in 18 V.S.A. § 9409, consisting of health care professionals who choose to participate and may propose criteria for forming and approving bargaining groups, and criteria and procedures for negotiations authorized by this section.

This project offers an opportunity to develop a single source health care system with state-of-the-art payment policies that reward efficiency. Vermont has already implemented quality measures and medical home models as part of Blueprint for Health and is preparing to implement an ACO pilot that provides financial rewards for quality and efficiency. Other ideas such as bundled payment are also a popular direction for reform (bundled payments include a single payment to a doctor or hospital team that then covers all related costs before during and after a hospital stay including, the physician fee, physician consults, re-admissions and post acute care).

In this analysis, we will review these payment methods and evaluate their merit for use in the design options. We may want to explore methods for improving these systems, such as developing ways to use partial capitation for some portion of patient care. In particular, it will be important to develop innovative ways of devising a payment system for people receiving care outside of the state.

About 30 percent of hospital care for Vermont residents is provided outside of the state. Although there is no reason an ACO could not be extended to an out-of-state hospital, Vermont

patients are likely to be a small share of their patient volume thus muting the cost containment effects. Also, the amalgamation of all Vermonters into a single system of care could enable the state to negotiate greater volume discounts with out of state providers.

In addition, we will estimate the effect of adopting a single system of care on payers in the state. We will also estimate the effects of the program on cost shifting. In the current system, hospitals and physicians recover the cost of free care provided to the uninsured by raising prices to privately insured patients to cover the cost of that care. Also, Medicaid and Medicare payments can be less than provider costs. These shortfalls in funding are shifted to private payers in the same way. A single system of care would eliminate uncompensated care and would eliminate differences in payment levels across patients, thus eliminating virtually all of the cost-shift.

6. Cost Containment

> (D) Cost-containment. Each design shall include cost reduction and containment mechanisms. If the design option includes private insurers, the option may include a fee assessed on insurers combined with a global budget to streamline administration of health services.

Throughout the study, we will design the system in light of the need for cost containment. This includes a need for administrative simplification and new payment systems that reward efficiency. The Lewin Group has prepared studies of savings for specific cost containment initiatives that could potentially be included in the Vermont design options. These have included both qualitative and quantitative evaluations of savings potential. We developed these analyses in the "Bending the Curve" study that we conducted for the Commonwealth Fund, and a recent analysis of cost containment options for the New York State Health Foundation.

We will draw upon this work in designing system reform options for Vermont. Some of the cost containment initiatives that we have studied include:

- Medical home model;
- Pay-for-performance;
- Accountable Care Organizations (ACOs);
- Bundled payment systems;
- Administrative simplification;
- Hospital pay-for-performance;
- Efficiencies for dual eligibles;
- Alternative primary care delivery systems;
- Tax on snack foods and soft drinks;
- Expanded use of palliative care;
- Savings from comparative effectiveness research; and
- Increased use of patient decision aids.

D. Coordinated Regional Health Systems

(2) Coordinated regional health systems. The consultant shall propose in each design a coordinated regional health system, which ensures that the delivery of health services to the citizens of Vermont is coordinated in order to improve health outcomes, improve the efficiency of the health system, and improve patients' experience of health services. The consultant shall review and analyze Vermont's existing efforts to reform the delivery of health care, including the Blueprint for Health described in chapter 13 of Title 18, and consider whether to build on or improve current reform efforts. In designing coordinated regional health systems, the consultant shall consider:

(A) how to ensure that health professionals, hospitals, health care facilities, and home- and community-based service providers offer health services in a coordinated manner designed to optimize health services at a lower cost, to reduce redundancies in the health system as a whole, and to improve quality;

(B) the creation of regional mechanisms to solicit public input for the regional health system; conduct a community needs assessment for incorporation into the health resources allocation plan; and plan for community health needs based on the community needs assessment; and

(C) the development of a regional entity, organization, or another mechanism to manage health services for that region's population, which may include making budget recommendations and resource allocations for the region; providing oversight and evaluation regarding the delivery of care in its region; developing payment methodologies and incentive payments; or other functions necessary to manage the region's health system.

It will be important for us to assure that the three design options are flexible enough to encompass programs implemented as part of the Blueprint for Health. The state has implemented pilots that change the financing system to reward chronic care management. The program also created Community Care Teams (CCTs) that assist doctors in implementing an effective medical home model and integrating public health with care delivery within individual communities.

We propose to conduct interviews with key members of the Blueprint program to better understand these programs and to identify ways in which these programs could be blended into the reform plans we are developing. These individuals may be included in the design sessions as well to be sure their views are heard.

E. Health System Planning

(3) Health system planning, regulation, and public health. The consultant shall evaluate the existing mechanisms for health system and facility planning and for assessing quality indicators and outcomes and shall evaluate public health initiatives, including the health resource allocation plan, the certificate of need process, the Blueprint for Health, the statewide health information exchange, services provided by the Vermont Program for Quality in Health Care, and community prevention programs.

Vermont has invested heavily in health system planning. In 2003, the legislature required BISHCA to develop a four-year Health Resources Allocation Plan (HRAP) to identify Vermont's health care needs in health care services programs and facilities. Their work is used as a resource document for policymakers and those involved in the CON process. The legislature

also created the Public Oversight Commission (POC) to coordinate oversight and regulation of health insurers and health care systems, and works with the Commissioner to periodically update the HRAP.

As discussed above, we will design the global budgeting system so that it builds off of the existing resource planning systems including CON, HRAP and the POC. These initiatives provide a foundation for a capital budgeting process that could have far more decision making authority.

F. Health System Financing

(4) Financing and estimated costs, including federal financing. The consultant shall provide:

(A) an estimate of the total costs of each design option, including any additional costs for providing access to and coverage for health services to the uninsured and underinsured; any estimated costs necessary to build a new system; and any estimated savings from implementing a single system.

(B) financing proposals for sustainable revenue, including by maximizing federal revenues, or reductions from existing health care programs, services, state agencies, or other sources necessary for funding the cost of the new system.

(C) a proposal to the Centers on Medicare and Medicaid Services to waive provisions of Titles XVIII (Medicare), XIX (Medicaid), and XXI (SCHIP) of the Social Security Act if necessary to align the federal programs with the proposals contained within the design options in order to maximize federal funds or to promote the simplification of administration, cost-containment, or promotion of health care reform initiatives as defined by 3 V.S.A. § 2222a.

(D) a proposal to participate in a federal insurance exchange established by the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 in order to maximize federal funds and, if applicable, a waiver from these provisions when available.

Throughout the project, we will provide analyses of the impact of each design option on health spending for major stakeholder groups including the state government, employers, providers and consumers. We will also show how federal spending on health care for Vermont residents is affected by each of the design options. These data will be used to assist Commission staff and other participants on the impact of the reform on these stakeholder groups. This will enable us to identify unintended consequences and revise the proposal. This will be particularly useful in evaluating the impact of taxes and other financing mechanisms on families by family income, and other demographic models.

The analysis would show the impact of the program on state-wide health spending and spending for major stakeholder groups (state-wide spending includes all expenditures for health services and administration). As part of this effort, we would estimate the amount of funding required to implement the program, and the amount of state and federal funding for existing programs that can be redirected to pay for the program. We would then examine alternative revenue raising measures to obtain any additional funds required to pay for the program.

We would work with the Commission to select the revenue raising measures. As part of the final report, we would include analyses of the effects of several alternative revenue raising

measures for each of the design options. As discussed below, our final report will include a detailed analysis of the impact of each of the three design options on health spending for major stakeholder groups. These include the following:

- Changes in sources of coverage for Vermont residents;
- Impact on total state-wide health spending including health services utilization, administrative costs, and savings from budgeting and delivery system reform;
- Changes in Vermont state government health spending including program spending, state worker health benefits costs and savings to other state programs;
- Changes in federal spending for Vermont residents;
- Impact on employer costs by firm size and current insuring status;
- Changes in family health spending by income, age and current insured status.

As discussed in a latter section, we will develop these estimates with a Lewin Group model of the health care system. We would use all relevant Vermont-specific data as inputs to the model. This includes the Vermont Household Survey, BISHCA data on health spending for Vermonters and other data available for the state.

G. Compliance with Federal Law

> (5) A method to address compliance of the proposed design option or options with federal law if necessary, including the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010; Employee Retirement Income Security Act (ERISA); and Titles XVIII (Medicare), XIX (Medicaid), and XXI (SCHIP) of the Social Security Act. In the case of ERISA, the consultant may propose a strategy to seek an ERISA exemption from Congress if necessary for one of the design options.

In the course of the analysis, we will attempt to design the options so that they are as consistent with federal law as possible. We would also identify areas where the state will need to obtain a waiver from federal law. Scott Wittman will be invaluable in identifying the changes that would be needed in the Vermont waivers to accommodate three design options.

The state would need to obtain some kind of waiver to cover Medicare beneficiaries under the new system. Because obtaining such a waiver will be difficult, we would structure the design options so that Medicare can continue to be the primary source of payment for this population with the design options providing wrap-around coverage for copayments and services not covered by the program.

There continues to be debate over whether ERISA prohibits a state from adopting a program covering all state residents. The consensus has been that we will not know until it is tested in court. Therefore it is probably prudent to seek an explicit waiver of ERISA for this purpose.

H. Project Task Plan

In this section, we reorganize the analyses described above into individual tasks. Much of the work described here will be conducted simultaneously so that various work products are ready when needed.

We anticipate that we will need up to 4 design sessions to finalize the details of the options to be analyzed. At the discretion of the Commission, we could consolidate some of the sessions to accelerate the design process. Similarly, we can conduct more than these 4 options design sessions if necessary. We will provide actuarial and modeling results in design sessions to assist in selecting major components of each design option.

Task 1: Initial Meeting in Vermont

The kick-off meeting for the project would occur early in the project. The purpose will be to review and revise our proposed task plan to reflect comments from Commission staff. We will also discuss the agenda for each design session meeting. We can arrange additional design sessions as necessary.

We would also identify the agency representatives that will participate in the process and identify the stakeholder groups to be included in the work groups and interviews. If possible, we will meet with representatives of relevant Vermont agencies.

Subtask 1-1:	Participate in meeting
Subtask 1-2:	Prepare Revised task plan based upon meeting results

Task 2: Set-up Models to Use Vermont Specific Models

In this task, we will rebase our modeling systems to use Vermont-specific data. This will include the household survey, population projections and estimates of health spending for Vermonter's. This assures that all estimates developed in the project are based upon Vermont data provided by BISCHA and others. The task is broken into the following subtasks:

Subtask 2-1	Incorporate Vermont household survey
Subtask 2-2	Use state health spending data by type of service and payment
Subtask 2-3	Adapt to Vermont population growth assumptions
Subtask 2-4	Control to Medicaid and Catamount health data
Subtask 2-4	Calibrate actuarial models to Vermont spending levels

Task 3: Conduct Stakeholder Work Groups and Interviews

In this task, we will prepare for and conduct the work groups and interviews with representatives of major stakeholder groups. All participants would be asked to participate once early in the project so that we can incorporate their ideas in the process. We would also ask them to be available to provide feedback on the design options developed in this process. The

results of these interviews and workgroups would be summarized for use in the options design process.

Subtask 3-1	Identify key participants
Subtask 3-2	Prepare interview materials for review by Commission staff
Subtask 3-3	Conduct initial interviews
Subtask 3-4	Prepare written summary of comments

Task 4: Options Design Session: Single-System Options

In Task 4 we will prepare for and execute the firsts design session. In this session we would outline the key features of the three delivery system design options. This would include specifying key features of the two options described in the law including single-payer and a public plan option. We would also work with Commission staff to identify a third single-system option, which could be a multi-payer option.

Once the options are defined, we would specify the following for each design option:

- Groups covered by plan;
- Provider payment levels and payment systems;
- Form of provider payment;
- Delivery system reforms;
- Financing mechanisms (Current public funding, premiums, payroll taxes, income taxes and consumer taxes);
- Required changes to the Medicaid waiver; and
- Other required changes in federal law (Medicare waiver, changes to ERISA).

We would prepare presentation materials discussing the range of alternative specifications for each design option for distribution prior to the design session and prepare a summary of what was selected. We would also present preliminary modeling results for these options that will be used to facilitate the discussion of options. The various subtasks include:

Subtask 4-1	Prepare list of potential design options and materials
Subtask 4-2	Present data and preliminary list of options
Subtask 4-3	Conduct session
Subtask 4-4	Prepare summary of meeting results for approval by participants

Task 5: Options Design Session: Payment Reform Options

The second options design session would be used to select payment systems for the design options. Our objective will be to identify provider payment systems that change provider incentives for quality and efficiency. These include the ACO model, a medical home model (as

under Blueprint for Health) with pay-for-performance incentives and bundled payment systems. In addition, we would include a review of payment systems used in other countries.

We would also review conventional payment systems for use in areas where these new payment models are not yet practical. Subtasks for this session include:

Subtask 5-1	Prepare payment system options summaries for use in session
Subtask 5-2	Present options and data on potential savings where available
Subtask 5-3	Present summary of methods used in other countries
Subtask 5-4	Conduct session
Subtask 5-5	Prepare summary of meeting results for approval by participants

Task 6: Options Design Session: Benefits Design

The third design session would be devoted to benefits design. This includes the list of covered services and alternative patient cost sharing requirements. This would include a comparison of the benefits options with the features of typical benefits packages in the individual and employer insurance markets.

We will facilitate the choice of benefits packages with an actuarial analysis of the cost of these benefits package. These estimates will show how changes in copayment amounts affect the cost of the benefits package. These estimates would also reflect the change in health services utilization levels as copayments are varied. This task includes:

Subtask 6-1	Prepare presentation materials for design session
Subtask 6-2	Prepare actuarial analysis
Subtask 6-3	Conduct design session
Subtask 6-4	Prepare summary of meeting results for approval by participants

Task 7: Options Design Session: Budgeting and Cost Control

In this session we will design a health expenditure budgeting process for Vermont and explore other cost containment options. This will include a review of health expenditure budgeting systems used in other health care systems around the world. We will also design a process for determining the appropriate levels of spending and identify ways of implementing these budgets through the payment systems that we selected in the prior design session.

To facilitate the process, we will prepare presentation materials on the range of approaches available for cost control and present available data on the effectiveness of various models. We will also prepare projections of health spending under alternative approaches. In addition, we will identify ways of building upon existing health resource planning initiatives now in place in Vermont. Key subtasks include:

Subtask 7-1	Prepare options for design session
Subtask 7-2	Develop long-term spending analyses

Subtask 7-3	Provide summary of approaches used in other countries
Subtask 7-4	Conduct design session
Subtask 7-5	Prepare summary of meeting results for approval by participants

Task 8: Stakeholder Feedback

In this task, we would obtain feedback from stakeholder group members included in the initial set of workgroups and interviews. After the design sessions are completed, we will supply these individuals with the written summaries of the program specifications prepared at the end of each of the four design sessions. We would then solicit comments from these groups for review by Commission staff. At this time, we could incorporate these comments into the three design options as appropriate. Subtasks include:

Subtask 8-1	Distribute design summaries to selected stakeholders
Subtask 8-2	Meet with stakeholders in person or over the phone
Subtask 8-3	Summarize feedback
Subtask 8-4	Revise design options if asked by Commission

Task 9: Modeling Tasks

As discussed above, we propose to supplement the design process with data and modeling of the available options. This will require us to set up the model early in the process to simulate health reform's effects on coverage and spending for affected groups in Vermont. We will rebase our models to use Vermont specific data including the Vermont household survey and health spending data provided by BISCHCA and other agencies.

This will also require us to simulate the effect of the PPACA on coverage and spending in Vermont once the system is implemented. As discussed below, the PPACA is complex and includes many changes affecting coverage, federal and state government spending, private employer health care costs and spending for consumers. Even the Medicare part-D prescription drug program is changed to increase the amounts of covered drug spending (i.e., eliminate the donut hole). It is important to model these elements of the Act correctly because the expansions in coverage reduce the net cost of implementing a single system of care in the state.

The Lewin Group model has already been modified to simulate the impact of the bill nationally and we are currently developing estimates for each of the 50 states. The primary change we will make in this analysis will be to modify the model to use additional Vermont-specific data. The various modeling subtasks include:

Subtask 9-1	Simulate Vermont health system under the PPACA
Subtask 9-2	Prepare a summary of PPACA impacts on the state
Subtask 9-3	Simulate design option 1
Subtask 9-4	Simulate design option 2
Subtask 9-5	Simulate design option 3

Subtask 9-6	Revise estimates as the design option is revised

Task 10: Modeling Benefits Packages

We propose to include actuarial analyses of the benefits packages used in the study. This will be based upon actuarial models available to The Lewin Group which reflect state variations in costs. These analyses will show how changes in the benefits package affect premium costs. This will include the effect of copayment amounts on the utilization of health services. Subtasks include:

Subtask 10-1	Actuarial analyses of benefits packages
Subtask 10-2	Actuarial analysis of cost sharing provisions
Subtask 10-3	Re-estimate program costs under selected design options

Task 11: Prepare Narrative Report

In this task we will prepare a report that presents the results of the study. It will include a summary of the process used to develop these options. We would also present background materials on coverage and spending in Vermont. This will include a summary of our estimates of the impact of the PPACA on the Vermont health care system and a discussion of the approach used to develop the design options selected for study. We will also present a detailed description of each option together with a detailed analysis of the option's impact on health spending for major stakeholder groups including:

- State Government health spending;
- Federal Government spending for Vermont residents;
- Private employer spending;
- Changes in consumer spending; and
- Changes in provider revenues by provider type.

The body of the report will be written at a level that is appropriate for a general audience. It will include an executive summary with side-by-side comparisons of the options and their effects on stakeholder groups. In addition, the report will include detailed appendices that describe the data and methods used that meets a high standard of technical documentation. Subtasks in the report writing process include:

Subtask 11-1	Prepare draft outline of report for review
Subtask 11-2	Prepare draft of report with results
Subtask 11-3	Revise to reflect comments
Subtask 11-4	Revise based on public comments

Task 12: Presentations in Vermont

The final task will be to conduct a presentation in Vermont to government agency representatives and law makers. We anticipate that we will travel to Vermont twice to present the results of our analyses. Subtasks include:

Subtask 12-1	Prepare presentation materials for review
Subtask 12-2	Deliver presentations in Vermont
Subtask 12-3	Respond to questions

I. Project Deliverables, Milestones and Timeline

Figure 2 presents our proposed list of deliverables for the project and the dates they a due. These deliverables will take the form of narrative text and presentations that we will prepare in a format suitable for inclusion in the final report. We propose to treat the delivery of these deliverables as project "milestones." ***Figure 3*** presents a proposed timeline for project completion.

Figure 2
Deliverables and Completion Dates

Task 1: Kick-off meeting in Vermont 7/29/10
Subtask 1-2: Prepare Revised task Plan based upon meeting results

Task 2: Set up models to use Vermont-Specific data 8/16/10
Subtask 2-5: Narrative description of data and methods used in the Vermont model

Task 3: Conduct Stakeholder Work Groups and Interviews 8/30/10
Subtask 3-2: Draft interview questions for stakeholder interviews and workgroups
Subtask 3-4: Narrative summary of results from interviews

Task4: Options Design Session: Single-System Options 8/10/10
Subtask 4-1: Initial list of potential design options
Subtask 4-4: Prepare Summary of design session meeting

Task 5: Options Design Session: Payment Reform Options 8/19/10
Subtask 5-1: Initial list of payment system options
Subtask 5-3: Summary of methods used in other countries
Subtask 5-5: Prepare Summary of Meeting Results

Task 6: Options Design Session: Benefits Design 8/30/10
Subtask 6-2: List of Benefits packages with actuarial analysis
Subtask 6-4: Summary of Meeting results

Task 7: Options Design Session: Budgeting and Cost Control 9/9/10
Subtask 7-2: List of options and long-term spending analysis
Subtask 7-5: Summary of Meeting results

Task 8: Stakeholder Feedback 10/15/10
Subtask 8-1: Prepare Summaries of design options
Subtask 8-4: Prepare summary of feedback

Task 9: Modeling Tasks 10/29/10
Subtask 9-2: Summary of the impacts of the PPACA on Vermont (presentation format)
Subtask 9-5: Summary of results from design options (presentation format)

Task 10: Modeling Benefits Packages 8/30/10
Subtask 10-4: Narrative description of benefits design options with actuarial analyses

Task 11: Prepare Narrative Report 1/1/11
Subtask 11-1: Prepare Report Outline
Subtask 11-2: Prepare Draft Report
Subtask 11-3: Revise Based on Commission comments
Subtask 11-4: Revised based on public comments

Task 12: Presentations in Vermont 2/1/11
Subtask 12-1: Prepare Presentation Materials

Figure 3
Proposed Timeline for Project

		Jul	Aug					Sep				Oct				Nov					Dec				Jan 2011					Feb	
		26	2	9	16	23	30	6	13	20	27	4	11	18	25	1	8	15	22	29	6	13	20	27	3	10	17	24	31	7	14
Task 1:	Kick-off meeting in Vermont 7/29/10																														
Task 2:	Set up models to use Vermont-Specific data	7/26-8/16																													
Task 3:	Conduct Stakeholder Work Groups and Interviews		7/29-8/30																												
Task4:	Options Design Session: Single-System Options		8/1-8/10																												
Task 5:	Options Design Session: Payment Reform Options			8/11-8/19																											
Task 6:	Options Design Session: Benefits Design				8/19-8/30																										
Task 7:	Options Design Session: Budgeting and Cost Control						8/31-9/9																								
Task 8:	Stakeholder Feedback								9/10-10/15																						
Task 9:	Modeling Tasks				8/17-10/29																										
Task 10:	Modeling Benefits Packages				8/15-8/30																										
Task 11:	Prepare Narrative Report													10/15-1/31/2011																	
Task 12:	Presentations in Vermont																													2/1-2/15	

V. Project Staffing

Successful completion of this project will require a multi-disciplinary project team with the range of skills required to redesign the state's health care system. The project team must include subject matter experts familiar with the state-of-the art thinking on payment system redesign in the U.S. and abroad. The team must also have extensive familiarity with the Vermont health care system, the Patient Protection and Affordable Care Act (PPACA), the unique Vermont Medicaid waivers, and the key sources of data on health care coverage and spending data for the state. Thorough analysis of the cost implications of reform will also require people skilled in actuarial analysis and modeling of complex health reforms.

The project would be directed by Mr. John Sheils of The Lewin Group, who has specialized in designing and analyzing major health reform proposals for nearly 25 years. He directed several health reform studies for Vermont including a single-payer analysis and policy simulations for VHAP and the Vermont legislature. Mr. Sheils often assists members of Congress and other health policy leaders in designing health reform proposals similar in scope to those requested here. Mr. Sheils recently directed the only private sector study of the cost impacts of the PPACA for the federal government and other major stakeholder groups. He is currently developing estimates of the cost impacts of the Act in each of the 50 states.

We include three consultants as subject matter experts. These include Mr. Scott Wittman of Pacific Health Policy Group, who played a vital role in designing the 1995 VHAP waiver, the Global Commitment waiver in 2006 and the Choices for Care waiver. We also include Mr. Steven Lieberman M.Phil., a Visiting Scholar at the Engelberg Center for Health Care Reform at The Brookings Institution, who specializes in ACO development and is currently providing consulting support to five ACO pilot sites. To provide an international perspective, we include Gerald Anderson Ph.D., who is a professor of international health system at the Johns Hopkins School Public Health, and is considered to be one of the nation's leading experts on health systems and payment practices.

Mr. Sheils will be assisted by Lane Keonig Ph.D., a former Lewin Group employee still working closely with The Lewin Group, who assisted the Vermont Health Care Reform Commission in developing a feasibility study for ACO pilot programs. We also include Mr. Steven Kappel as our expert on Vermont data and health system who has held several positions in Vermont state government.

Due to the multidisciplinary nature of the project team, careful management is important. We include Ms. Evelyn Murphy of The Lewin Group, who will manage timely completion of all deliverables. Our project team also includes: Mr. Randy Haught who is responsible for health reform modeling at Lewin; Mr. Thomas Carlson, FSA, MAAA, a Lewin Group actuary; and Peter Welch Ph.D., who directed our recent analyses of bundled payment systems for the New York Healthcare Foundation (NYHF) and the Commonwealth Fund.

In this section we describe the backgrounds of the proposed project team and describe their role in the study. Resumes for the proposed project team members are presented in ***Appendix A***. We begin with a description of the items required from state agency officials during the course of the project.

A. Working with Vermont State Employees

We have included in our project team people with the full range of knowledge and resources required to carry out all of the tasks and subtasks described in this proposal. We are prepared to develop all interview materials, reports and data analyses required to complete the project. However, we will request certain inputs from some Vermont state Government personnel.

We will need to work with agency staff in obtaining and understanding the data and analyses available from Vermont state agencies. These include the Vermont Household Survey and state health spending estimates. We will also need to obtain forecasts of population growth, health expenditures, and public program enrollment and spending. To facilitate this process, we have included Mr. Steven Kappel, who has extensive familiarity with the Vermont data. This should minimize time required from state data sources.

Also, to assure that the three design options dovetail with existing health initiatives, we will need to interview agency officials responsible for those programs. These include chronic care initiatives under the Blueprint for Health and various state health planning entities including the HRAP, CON and the POC.

In addition, we will need to work with the appropriate Commission staff in working through the three design options. As discussed above, we are pleased to include other state agency officials in the proposed design sessions. ***Figure 4*** presents our estimates of hours by project team member by task.

B. Project Director

Mr. John Sheils. Vice-President, The Lewin Group

Expertise: Familiarity with the PPACA**;**
Experience estimating savings from payment reforms;
Experience directing complex design projects; and
Health system modeling

Project Role: Oversee and coordinate all tasks and subtasks under the project;
Lead the Modeling process;
Participate in design sessions; and
Participate in presentations in Vermont

Mr. John Sheils will serve as Project Director for this project and will participate in all tasks under the project. He has directed several studies for state-level Commissions charged with identifying and analyzing the effect of alternative health reform options. He directed a similar project in Vermont in 2001 and most recently worked with a health reform task force in Colorado (i.e., the 208 Commission report). He has also directed a recent series of widely quoted studies showing the cost and coverage impacts of the PPACA at various stages of its progress through Congress.

Figure 4
Project Hours by Person and Task

	Task 1 Kick-off	Task 2 Model Set up	Task 3 Interviews	Task 4 Design Options	Task 5 Payment Reform	Task 6 Benefits Design	Task 7 Budgeting & Cost Control	Task 8 Interviews	Task 9 Modeling Tasks	Task 10 Model Benefits Package	Task 11 Narrative Report	Task 12 Presentations	Total
John Sheils	8		8	12	12	12	12	2	14	8	32	18	**138**
Tom Carlson		3				20			4	12			**39**
Randy Haught		24							80	8	4		**116**
Evelyn Murphy	4	4	8	8	8	8	8	3	8	2	18	4	**81**
Pete Welch					12						24		**36**
Scott Wittman	8			12	12	12	16				60		**120**
Steve Lieberman					16		8		2		12	12	**50**
Lane Keonig	8		45	8	8			40			90		**199**
Gerald Anderson				12	4		22		3		32	12	**85**
Steve Kappel		16	10			10		10			40		**86**
Total	**28**	**47**	**71**	**52**	**72**	**62**	**66**	**55**	**111**	**30**	**310**	**46**	**950**

He has assisted several members of Congress in specifying health reform proposals designed to expand coverage and reduce costs. Mr. Sheils has testified before various Congressional committees and has delivered policy briefings to state task forces, federal commissions, private associations and industry representatives on national health policy. He also directed The Lewin Group analysis of savings from he payment system reforms that formed the basis of the Commonwealth Fund "Bending the Curve" study. Mr. Sheils recently directed a similar analysis of options for reducing health care costs in New York, including ACOs, bundled payments and other changes.

Mr. Sheils has specialized in economic and financial analyses of the impact of changes in the health care system on key stakeholders including governments, employers, consumers and health providers. He recently directed a Lewin Group analysis of the coverage and cost containment provisions of the health reform proposal signed into law by president Obama. He also authored the Lewin Group analysis of the cost and coverage impacts of the 2008 presidential candidate's health reform proposals, which was widely quoted in the press. Mr. Sheils has also assisted several private clients in evaluating the impact of reform on their businesses.

Mr. Sheils specializes in the use of microeconomic databases and micro-simulation techniques to analyze health, retirement, tax and income maintenance policy issues. He is the architect of The Lewin Group Health Benefits Simulation Model (HBSM).

C. Subject Matter Experts

Mr. Scott Wittman JD, Corporate Director, The Pacific Health Policy Group (PHPG)

Expertise: Designer of three Vermont Medicaid waivers;
Adapting the Vermont waivers to the PPACA; and
Knowledge of Vermont health care system

Project Role: Identify changes in Medicaid waivers required under design options;
Provide expertise on state program payment systems; and
Assist in design options process

Mr. Wittman has assisted with all facets of Vermont's reform of its Medicaid program through development and implementation of two Section 1115(a) waiver programs – *Global Commitment to Health* and *Choices for Care*. The projects included defining eligibility standards and drafting state regulations in accordance with state objectives and in compliance with federal law and policies. Currently, Mr. Wittman is assisting the state with the extension of both Demonstrations and is reviewing the impact of federal reform on existing eligibility groups and identifying opportunities for revising eligibility criteria. Mr. Wittman's work on behalf of public sector clients has included:

- Analysis of federal, state and local legislation, regulations, and policies as they pertain to proposed program models;
- Analysis of state legislation, regulations, and policies for consistency and conformity with both federal and other state legislation, regulations, and policies;

- Analysis of historical Medicaid expenditure and utilization data, as well as managed care organization (MCO) encounter data for purposes of developing detailed financial projections to support strategic planning, budgeting and rate-setting activities;
- Evaluation and development of alternative cost sharing and benefit structures and other initiatives, including public-private partnerships and health savings accounts;
- Development of financial models testing the impact of various programmatic, eligibility, and benefit changes;
- Development and implementation of program monitoring tools, including audit guides and performance evaluation guides;
- Development of Section 1115(a) and 1915(b) waiver proposals;
- Development and implementation of operational, clinical, and financial reporting systems;
- Development of contractual performance standards;
- Development of Medicaid reimbursement methodologies and rates for numerous provider types, including hospitals, physicians, nursing facilities, home health agencies and community mental health centers;
- Evaluation and development of long-term care initiatives; and
- Assisting in the development of Medicaid managed care strategies for health maintenance and provider-sponsored organizations.

Prior to joining PHPG in 1994, Mr. Wittman served as a Manager in KPMG Peat Marwick's Government Services Practice, where his duties included evaluation, development, and implementation of health care programs for public sector clients. Prior to KPMG, Mr. Wittman worked for the American Hospital Association as a policy analyst. Mr. Wittman graduated from the Loyola University of Chicago School of Law and is a member of the Illinois Bar. He received his BA in Political Science and Economics from Knox College.

Mr. Seven Lieberman, M.Phil, Visiting Scholar, Engelberg Center for Health Care Reform, Economic Studies Division, The Brookings Institution

Expertise: Familiarity with state-of-the-art payment systems; and
Knowledge of existing payment systems in public programs; and
Familiarity with systems used in the private sector.

Project Role: Consult on the design of ACOs and other Delivery system reforms; and
Participate in relevant design sessions in Vermont

Mr. Lieberman is working with Mark McClellan and as part of the Brookings collaboration with The Dartmouth Institute headed by Elliott Fisher, specializing in the development of Accountable Care Organizations (ACOs). He is currently co-editing a "user's manual" on ACO implementation, and is providing consulting support to 5 ACO pilot sites. He also served as a faculty member for the Brookings—Dartmouth ACO learning network. In addition, Mr. Lieberman has private industry experience in the development of payment systems. He has also studied competitive bidding models for Medicare Advantage plans.

Mr. Lieberman is an independent consultant engaged in Medicare, Medicaid and private sector research, policy, data, and budgetary analyses. He serves a broad range of providers and provider associations, pharmaceutical and device manufacturers, insurance and managed care companies, trade associations, and the Centers for Medicare & Medicaid Services (CMS). He specializes in applying empirical and economic analyses to inform policy and business issues, such as those involving Medicare reimbursement and coverage.

Mr. Lieberman's experience includes three years as managing partner of The Moran Company. He led implementation of Medicare Modernization Act, serving as Executive Director of the CMS MMA Council. He also served as Congressional Budget Office (CBO) Assistant Director where he was responsible for analyses of Medicare prescription drug and reform proposals, as well as conducting research on high cost Medicare beneficiaries, regional variations in cost, risk pool size, and partial capitation. Mr. Lieberman was also a Vice President for Government Programs and Marketing at Intergroup Healthcare Corporation (IGHC).

Gerald F. Anderson, PhD, Professor of International Health, Johns Hopkins University Bloomberg School Public Health

Expertise:	Familiarity with payment systems in other countries; Familiarity with Health Budgeting in other countries; and Experience with payment systems under federal programs
Role:	Advise on alternative system designs based on International comparisons; Advise on budgeted systems and alternative payment system designs; and Participate in relevant options design sessions in Vermont

Gerald Anderson, Ph.D., is currently conducting research on chronic conditions, comparative insurance systems in developing countries, medical education, health care payment reform, and technology diffusion. He has directed reviews of health systems for the World Bank and U.S.AID in multiple countries. He has authored two books on health care payment policy, published over 200 peer reviewed articles, testified in Congress over 35 times as an individual witness, and serves on multiple editorial committees. Dr. Anderson publishes regular updates of international health systems for the Commonwealth Fund.

Dr. Anderson is also a professor of health policy and management at the Johns Hopkins University School of Medicine, director of the Johns Hopkins Center for Hospital Finance and Management, and co-director of the Johns Hopkins Program for Medical Technology and Practice Assessment. He recently stepped down as the National Program Director for the Robert Wood Johnson Foundation sponsored program "Partnership for Solutions: Better Lives for People with Chronic Conditions."

Prior to Johns Hopkins, Dr. Anderson held various positions in the Office of the Secretary, U.S. Department of Health and Human Services, where he helped develop Medicare prospective payment legislation.

D. Consultants

Lane Koenig, PhD, President, KNG Health Consulting, LLC

Expertise: Knowledge of Vermont health system and stakeholders;
Experience with Vermont delivery system reforms; and
Knowledge of alternative payment systems

Project Role: Plan and conduct interviews with stakeholder groups;
Participate in options design sessions; and
Assist in drafting the final report

Lane Koenig, Ph.D., President of KNG Health Consulting, LLC, is a health care economist with over 13 years of experience in the public and private sectors. He specializes in conducting policy and data-driven analyses to study a broad range of health care issues, including provider reimbursement policy, provider efficiency, healthcare spending growth, and the costs and benefits of medical interventions, such as disease management and substance abuse treatment. Dr. Koenig has performed three delivery system reform projects for Vermont including:

- **Vermont Blueprint for Health Primary Care Payment Reform Model.** Conducted structured interviews with payers and providers to recommend a detailed primary-care payment reform model that could be implemented throughout the state;
- **Medical Home Pilots in Vermont**. Conducted interviews with payers and providers, and facilitated meetings between stakeholders to reach agreement on pilot parameters, and proposed a payment model for the pilots that formed the foundation of the approach used by the state; and
- **Feasibility of Testing the Accountable Care Organization (ACO) Model in Vermont**. Assisting the Commission by jointly facilitating meetings with stakeholders and assisting in developing a potential design for the pilot.

Prior to KNG Health, Dr. Koenig was the chief economist in the Office of Policy at the Centers for Medicare and Medicaid Services (CMS) where he specialized in the drug pricing and the Medicare part-D program. Dr. Koenig was a Senior Scientist at The Lewin Group, where he spent 7 years in the Health Care Finance practice. At Lewin, he focused on long-term and acute care hospital and physician payment issues. He authored a report on the potential impact of adopting the medical home model on primary care practices. He earned his B.A. with honors from the University of Florida, Gainesville and earned his Ph.D. in Economics from the University of Maryland, College Park.

Steven J. Kappel, Founder, Policy Integrity, LLC

Expertise: Knowledge of Vermont-specific data sources; and
Knowledge of Vermont health care system and stakeholders

Project Role: Provide expertise on Vermont data; and
Participate in stakeholder interview process

Mr. Kappel is a health care policy consultant with a broad understanding of all aspects of Vermont's health care system, from financing to outcomes research, combined with significant management experience. Mr. Kappel assists clients with the development, presentation, and evaluation of policy alternatives in health care and related areas. Examples of his work in Vermont include:

- **Vermont Commission on Health Care Reform**. Enhanced existing models and designed new models to explore Accountable Care Organizations built around local hospitals;
- **Center for Health Policy, Planning, and Research; University of New England**. Member of a team which evaluated Vermont's most recent health care reform efforts;
- **Vermont Children's Health Improvement Project (VCHIP); University of Vermont**. Member of a team tasked to "Create Decision Support Systems, quality and cost data analysis to support state sponsored and other program beneficiaries in receiving the highest quality and most cost effective services;" and
- **Joint Fiscal Office; Vermont Legislature.** Several projects, including building a model to explore the potential administrative savings of real-time claims processing, development of models to project Catamount Health enrollment, and updating of a model to project savings from a "single-payer" hospital system in Vermont.

Mr. Kappel's prior work experience in Vermont includes: Associate Fiscal Officer, Vermont Joint Fiscal Office; Executive Director, Vermont; Program for Quality in Health Care, Inc.; Director of Analysis and Data Management, Department of Banking, Insurance, Securities and Health Care Administration; Data Manager, Vermont Health Care Authority; and Director of Data Management BlueCross BlueShield of Vermont. Mr. Kappel holds a Masters of Public Administration (MPA) from the University of Vermont.

E. Lewin Group Staff

Randall Haught, Managing Director, Health System Modeling

Expertise: Experience in simulating the effects of the PPACA;
Experience estimating the impact of delivery system reforms; and
Knowledge of alternative payment systems

Project Role: Perform all policy simulations of design options; and
Prepare modeling documentation

Mr. Haught's primary area of expertise is in data analysis and micro-simulation modeling of health care financing and policy related issues. He directed the modeling of the PPACA for recent Lewin Group reports as the bill moved through Congress. He has extensive experience in estimating the impacts of major healthcare reform initiatives on health spending for households, employers, and various levels of government. He has performed these analyses for Vermont and other states and performed analyses of national health reform initiatives for the Robert Wood Johnson Foundation. Mr. Haught has also performed several in-depth financial analyses measuring the adequacy of Medicaid hospital payment rates for the Pennsylvania Legislative Budget and Finance Committee, the Massachusetts Department of Medical Assistance, the Oregon Association of Hospitals and Health Systems, and the Kentucky

Hospital Association. Mr. Haught has extensive experience in Medicare payment policy and has assessed the financial impact on providers of major payment policy changes under the Balanced Budget Act, Balanced Budget Refinement Act, and the Medicare and Medicaid Benefits Improvement and Protection Act. Mr. Haught received a BS with honors in mathematics from Waynesburg College.

Mr. Thomas P. Carlson, FSA, MAAA, Lewin Group Actuary

Expertise:	Benefits Design Analyses
Project Roll:	Assist in specifying benefits packages; and Perform actuarial analyses for alternative benefits packages

Mr. Carlson has 16 years of actuarial consulting experience in a variety of settings, including setting rates for Medicaid and commercial managed care. He recently developed estimates of the cost-sharing amounts that would correspond to the benefits defined in the PPACA, which indicates only the actuarial value of the packages plans must offer in the exchange. Recent work has centered on the provision of actuarial services and Medicaid program operations and policy. He has extensive experience analyzing state and federal health policy, evaluating Medicaid initiatives, and providing technical assistance for capitating commercial and government health care programs. Mr. Carlson holds a Masters in Economics from the University of California, Los Angeles and a BS in Economics from the University of Minnesota.

Ms. Evelyn Murphy, **JD, MPL,** Senior Consultant, The Lewin Group

Expertise:	Management of complex projects with several staff and consultants; and Experience preparing descriptions of policy options
Project Role:	Coordinate efforts to meet deliverable dates; and Handle all state and subcontractor contracting

Ms. Murphy served as manager of several state-level projects to design and analyze the impact of alternative proposals to expand health insurance coverage including Alabama, Mississippi and Colorado. Ms. Murphy's health reform work has included managing the Colorado Blue Ribbon Commission on Health Care Reform project. The project involved working with several authors and the Commission and analyzing the cost and coverage impacts of several health reform proposals. She also worked on a Maryland individual mandate project. In addition, Ms. Murphy has managed state health reform initiatives in Indiana, Wisconsin, Mississippi and Hawaii.

Ms. Murphy's work in the managed care arena involved Managed Care Organizations' Readiness Reviews for the State of Texas, Health and Human Services Commissions (HHSC)'s. She also assisted West Virginia on their 1915 (b) & (c) waiver renewal application and member satisfaction survey. Long-term care work at Lewin includes providing expertise and support to the State of Washington's Task Force on Long Term Care Financing and Chronic Care Management. Ms. Murphy holds a Jurist Doctorate from Indiana University School of Law and a Masters in Planning from the Indiana University School of Public and Environmental Affairs.

W. Pete Welch, PhD, Senior Consultant, The Lewin Group

Expertise:	Knowledge of existing payment system; and Published research on bundling and other reforms
Project Role:	Internal review of all payment system design task Provide write-up of conventional payment systems for report

Pete Welch, Ph.D. has more than 25 years of experience in health services research. Dr. Welch combines academic skills with hands-on experience in a managed care organization (MCO), where he worked with data received from many provider types (e.g., drug claims and laboratory results). He worked at the Urban Institute for almost a decade, was Research Director of a trade association, taught at the University of Pittsburgh, and served in government at the Office of Management and Budget (OMB) and the Congressional Budget Office (CBO).

Much of this work pertained to Medicare payment policy, which will continue to offer options to encourage HIT/HIE use. With colleagues, Dr. Welch performed the first multi-practice analysis of the impact that electronic health records have on quality and cost of care (*JAMIA*, 2007). In 2001 he participated in the HIE debate over a Medicare requirement that MCOs transmit data for risk adjustment (*J of Ambulatory Care Management*, 2002). He has published more than fifty articles in peer-reviewed journals and was on the editorial board of *Medical Care Research and Review* for a decade. Dr. Welch earned a BA in Economics from Swarthmore College and a Ph.D. in Economics from the University of Colorado.

VI. Data Sets and Models

This project will involve one of the most challenging modeling exercises we have encountered. To model the design options, we must first simulate the effect of The Patient Protection and Affordable Care Act (PPACA) on health coverage and spending in Vermont before we can measure the impact of the design options that we will develop in this project. This is because the net effect of the design options is determined by comparing projections of coverage and spending under each design option to projections of what coverage and spending will be under the PPACA.

Accounting for the effects of the PPACA on Vermont is essential to understanding the effects of further reforms. The Act will increase coverage, improve benefits under Medicare Part D (drug coverage), cut provider payments under Medicare and increase the amount of federal funding coming into Vermont through new subsidies. This is crucial to this study because the single-system reforms are built on the idea that existing state and federal funding for health care could be taken and used to provide care for all Vermonters through a more efficient system. Thus, the increase in federal funding for Vermont residents under PPACA serves to reduce any new revenue needs required to implement a single-source health system for the state.

The Lewin Group produced several studies of the PPACA as it progressed through Congress over the last year, and is now developing impacts estimates for each of the 50 states. We are the only private entity that has modeled the combined effect of the bill on major stakeholder groups including the federal government, state and local governments, private employers, providers and consumers. This is at least partly due to the complexity of the bill and the challenges in modeling the new incentives created under the bill. (The executive summary of our analysis of the final bill is presented in ***Appendix B***.)

In this study, we will "rebase" our models so they are based upon the most recent data available for Vermont including the Vermont Household Survey, BISHCA data on health expenditures for Vermont residents and Vermont program data. The Lewin Group model, the Health Benefits Simulation Model (HBSM), has been used for reform analyses at the state and federal levels continually for over 22 years. It has benefitted from technical review and critique by major authorities on simulation modeling and is regularly revised to include the most recent data and research available.

In this section, we describe The Lewin Group model and the steps we will take to customize it for use in Vermont. We then describe the analyses we will provide for the various design options. We begin by summarizing the major coverage financing provisions of the PPACA.

- The Patient Protection and Affordable Care Act (PPACA);
- Adapting the Health Benefits Simulation Model (HBSM) to Vermont; and
- Simulations of single-system design options

A. The Patient Protection and Affordable Care Act (PPACA)

The PPACA requires most Americans to have health insurance. To assure access to affordable coverage, the Act expands the Medicaid program to cover all low-income adults living below

133 percent of the federal poverty level (FPL). The Act also provides a new premium subsidy program for people living below 400 percent of the FPL ($88,000 for a family of four). In addition, the Act reforms the insurance markets by requiring guaranteed issue of insurance without exclusions for pre-existing conditions, and prohibits carriers from denying coverage or increasing premiums on the basis of individual health status.

The Act also provides a small employer health insurance tax credit for the employer's first two years of providing coverage. The credit is available to firms with fewer than 25 workers with an average employee payroll of less than $50,000. The Act also creates a temporary reinsurance program for employer sponsored retiree benefits, although the program includes only enough funding for two to three years of operation.

The centerpiece of the Act is a newly established "exchange" that presents consumers with a selection of health coverage alternatives. The exchange will be available to individuals and firms with fewer than 100 workers, although the state has the option to extend the exchange to larger firms beginning in 2017. Only people participating in the exchange who do not have access to qualifying employer coverage will be eligible for the premium subsidies.

The PPACA creates penalties for both employers with uncovered workers and individuals who do not have coverage.

- **Employer penalties:** Non-insuring employers with more than 50 workers pay a penalty if one or more of their workers obtain premium subsidies in the exchange. The penalty amount is equal to the lesser of $3,000 for each full-time worker receiving a premium credit, or $2,000 for each full-time worker; and
- **Individual penalties:** The Act imposes a penalty on uninsured individuals equal to the greater of $695 and 2.5 percent of income, not to exceed $2,085.

The Act is funded with reductions in spending under Medicare and additional federal tax revenues. The Act creates a new excise tax on high cost health plans (premiums over $10,200 for individuals and $27,500 for families). It also includes a second excise tax on health insurance, and new excise taxes on branded prescription drugs and device manufacturers.

The federal government pays all of the cost of the expansion in Medicaid through 2016. A state matching requirement of 10 percent is phased-in by 2019. The Act increases the Federal Medical Assistance Percentage (FMAP) for the Children's Health Insurance Program (CHIP) by 23 percentage points, up to a maximum of 100 percent.

B. Creating a Model of the Vermont Health Care System

To develop a simulation model of the Vermont health care system, we will rebase the Lewin model to use all of the most recent data available for the state. This will include the Household Survey data for Vermont, health spending data for Vermont residents and Vermont program data for VHAP and the Catamount health program.

1. *The Health Benefits Simulation Model (HBSM)*

The Health Benefits Simulation Model (HBSM) is a micro-simulation model of the health care system. HBSM is a fully integrated platform for simulating policies ranging from narrowly defined Medicaid coverage expansions to broad-based reforms such as changes in the tax treatment of health benefits. The model is also designed to simulate the impact of numerous universal coverage proposals such as single-payer plans and employer mandates.

The key to simulating changes in the health care system is to develop a baseline database that depicts the health care system in detail at national or state levels. Our HBSM baseline data is based upon the 2002 through 2005 Medical Expenditures Panel Survey (MEPS) data, which provide information on sources of coverage and health expenditures for a representative sample of the population. At the national level, these data are adjusted to reflect the population and coverage levels reported in the 2009 Current Population Survey (CPS) data or another household survey for an individual state.

The model also includes a database of employers for use in simulating policies that affect employer decisions to offer health insurance. We used the survey of employers conducted by the Kaiser Family Foundation and the Health Research and Educational Trust (HRET). These data include about 2,000 randomly selected public and private employers with 3 or more workers, which provide information on whether they sponsor coverage and the premiums and coverage characteristics of the plans that insuring employers offer.

HBSM simulates a wide variety of changes in Medicaid and SCHIP eligibility levels for children, parents, two-parent families, and childless adults. It models changes in income eligibility levels using the household income data provided in the household survey. It also models: certification period rules, deprivation standards (i.e., hours worked limit for two-parent families), "deeming" of income from people outside the immediate family unit and other refinements in eligibility. As under the program, the model simulates eligibility on a month-by-month basis to estimate part-year eligibility.

HBSM also models the effects of proposals designed to expand coverage by changing the cost of insurance to the employer and/or the employee. These include employer tax credits, premium subsidies and other programs that subsidize and/or reduce the cost of insurance to the employer. We assume that premium subsidies will be viewed by employers and employees as a reduction in the cost of insurance, resulting in a price response by both employers and workers. We estimate these price responses using Lewin Group multivariate analyses that measure how the likelihood of offering and taking coverage carries with the price of coverage. These models include:

- **Employer Decision to Provide Coverage:** The PPACA includes tax credits to small employers as an incentive to provide coverage and creates financial penalties for larger firms that do not cover their workers. The model simulates the effect of employer premium subsidies as a reduction in premiums that increases the likelihood that the employer will provide coverage. We model the impact using a multivariate model of the employer decision to offer coverage which reflects the impact of price on the employer's purchase decision. We used the 1997 RWJF Survey of Employers to estimate a multivariate model that shows how the likelihood that a firm will offer coverage varies

with wage level, workforce composition, firm size, industry, other firm characteristics and the price of health insurance.

- **Individual Decision to Purchase Coverage:** The PPACA provides tax credits on a sliding scale with income for the purchase of individual insurance to people who do not have access to employer coverage, and creates financial penalties for going without coverage. We simulate the impact of these proposals as a reduction in the cost of insurance. We estimate the response with a multivariate model of the likelihood that an individual will purchase coverage developed by The Lewin Group. This multivariate model was estimate based upon a pooled time-series cross-section analysis of private employer coverage reported in Census data.

2. HBSM Baseline for Vermont

Vermont has excellent data on population demographics, income and sources of insurance coverage. Unfortunately, these data do not include the household health expenditure data included in the MEPS data used in HBSM. We address this by re-weighted the MEPS household data for the northeast region of the U.S. to reflect population control totals reported in the Vermont household data for up to 200 separate counts of Vermonters across income and demographic groups, including source of insurance. We also adjust the expenditures data in the file to match BISCHA health expenditure data by type of service and source of payment.

The result is a database that reflects all of the population and health expenditure data available for the state. We also use only the MEPS and health plan survey data for the northeast region of the U.S. which is the most detailed geography provided in these data. In this process, the underlying MEPS and employer data are used only to provide an assumed distribution of costs across the Vermont population, where the number of people and total levels of health spending replicate the distributions reported in the Vermont-specific data. This is similar to the approach used to simulate geographic variation in many actuarial models.

These weight adjustments are performed with an iterative proportional-fitting model, which adjusts the sample weight to match approximately 200 separate classifications of individuals by socioeconomic status, sources of coverage and job characteristics in the Vermont data.[1] This approach permits us to simultaneously replicate the distribution of people across a large number of variables while preserving the underlying distribution of people by level of health care utilization and expenditures as reported in MEPS.

To assure that our analyses are as Vermont-specific as possible, we will also review other data sources collected by the federal government that include a separate subsample for individual states, such the Medical Expenditures Panel Survey data for employers.

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1 Iterative proportional fitting is a process where the sample weights for each individual in the sample are repeatedly adjusted in a stepwise fashion until the database simultaneously replicates the distribution of people across each of these variables in the state.

C. Simulations of Design Options

The Vermont-based model will be used to simulate the effects of reform on coverage and spending in Vermont. We will use the Vermont-based model to simulate changes in coverage and spending under the AAPCA. We will then adopt the results as the Baseline for the analysis. This PPACA baseline will be used to evaluate the effects of each design option selected for study. The effects of the design options are measured as the difference between the design option results and the results estimated in the PPACA baseline.

The analysis will show the impact of each design option on total health spending in Vermont, which includes all health spending for Vermonters regardless of the source of payment. We will also show the impacts for major stakeholder groups including the state government, the federal government, private employers, providers and consumers. Our 2001 study of a single-payer system for Vermont provides an illustration of the results we would develop for each of the three design options.

1. *Impact on Total Health Spending for Vermonters*

One of the arguments in favor of adopting a single-system model such as single-payer is that it will cover everyone while actually reducing the amount spent on health care overall. To test this hypothesis, we will estimate the various effects the program would have on total state-wide health spending, including payments for health services and administrative costs. For example, we will use the model to simulate the increased utilization among newly insured people and additional utilization for currently "under-insured" people as they become covered under a more comprehensive benefits package.

We will also model the impact of changes in the delivery system such as expanded emphasis on primary and preventive care and new payment systems such as ACOs and bundled payments. Our study will also include a detailed analysis of the impact of the program on administrative costs in the system. The cost of administration includes the insurer's cost of providing benefits including: claims processing, marketing, enrollment and profit/risk. Administrative costs also include the provider's cost of filing claims, adjudicating claims and negotiating payment levels with carriers. A single health system such as the single-payer model would reduce these administrative costs by:

- Eliminating insurer functions such as marketing, network formation and profit; and
- Simplifying the provider payment process through a single provider payment schedule with standardized rules that reduce claims adjudication processes.

2. *Impact on Government Health Spending*

Depending upon its design, a single-system reform option would have a major impact on state spending and revenues. For example, single-payer proposals usually establish a government health benefits program that is funded with dedicated tax revenues such as a payroll tax. In this study, we would estimate Vermont state government costs and revenues for each design option.

It will also be important to estimate the effects of these design options on federal spending and revenues for Vermont. Because single-system reform proposals generally assume that current government spending for health is recovered and used to pay for the new system of coverage, we will need to identify the amounts that the federal government will spend on health care for Vermonters under the PPACA.

In addition, we will estimate the effects of each design option on federal tax revenues. This is important because under current law, employer contributions for health insurance are exempt from federal income and payroll taxes. Thus, any reform that changes what employers spend for health benefits will have tax consequences for Vermont taxpayers that could be either favorable or unfavorable.

3. Impact on Employers

As the primary source for coverage in the U.S., employer health spending can be dramatically affected by system-wide reforms. For example, under some proposals for a single-system of care, employers would pay a payroll tax but would no-longer have expenses for premiums or the employer penalties under PPACA for not offering insurance. The impact on employers is the difference between the payroll tax payment and the premiums/penalty payments under the baseline health system. These effects would vary across employers depending upon their current costs for insurance and total worker payroll.

The modeling will identify patterns in the change in employer costs by firm size, industry and current insuring status and worker payroll levels. For example, we would estimate the following for Vermont employers under each design option:

- Change in total health spending for private employers;
- Changes in employer spending for currently insuring and non-insuring employers;
- Impact of key provisions on retiree health spending;
- Changes in spending due to financing provisions of the plan such as a payroll tax (if specified);
- Net change in spending by firm size; and
- Net change in spending by industry.

4. Consumers

It will be important to understand the effects of these design options on families. Family spending for health care includes out-of-pocket spending for non-covered services, copayments for covered services, worker premium contributions for employer coverage, premium payments for individually purchased insurance, and Medicare premium payments and supplemental insurance coverage for Medicare recipients.

Our Vermont baseline data will include estimates of the amounts paid by each family in the household data for each of these types of premium and out-of-pocket costs under the PPACA. In this study, we will estimate how these spending amounts would be affected under each

design option. This is an important element of the analysis because family spending for health services will be shaped by the coverage and coinsurance requirements under the single-system design option. Financing provisions for each option will also affect family premium and tax payments for health.

We would estimate the impact of each design option on households including:

- Changes in consumer out-of-pocket expenditures for health care;
- Reduction in family premium payments;
- Increase in consumer tax payments to fund the program (e.g., payroll tax etc.);
- Changes in wages resulting from changes in employer costs (i.e., changes in employer health spending are generally thought to be passed-on to workers in the form of wage changes over-time); and
- Changes in average family health spending by income, age, insured status under current law and other socio-economic groups.

5. Provider Impacts

Finally, we will estimate the impact of each design option on health care providers including hospitals and physicians. Provider incomes in Vermont will be determined by the design of each single-system plan. For example, provider incomes will be driven by the health care budgets set for the state and the payment levels used for individual health services. Provider incomes will also increase as utilization of health services increases for newly insured people and as providers receive payment for services that they would have provided free to uninsured people under current law (i.e., reduced uncompensated care).

HBSM is designed to model these effects, given available information on payment levels for care under public programs for the state. In addition, we will estimate the cost impact of the delivery system reforms included in each option. These include expanded primary care, ACOs, medical homes, increased use of palliative care and other changes such as administrative simplification. The Lewin Group has conducted several studies of the potential effects of these initiatives that have been widely referenced in the recent health reform debate.

V. References

We encourage the Commission to contact our references. More are available upon request.

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Appendix A: Resumes

JOHN F. SHEILS
SENIOR VICE PRESIDENT

EDUCATION

M.S., with Honors, Public Policy, School of Urban and Public Affairs, Carnegie-Mellon University

B.S., summa cum laude, Political Science, State University of New York at Brockport

EXPERIENCE

Since Mr. Sheils joined firm in 1980, he has worked to establish The Lewin Group as one of the few independent sources of non-partisan analyses of the financial impacts of public coverage expansions and other health reform initiatives. He has testified before various Congressional committees and commissions on health reform options and is regularly quoted in the press. He often works directly with members of Congress in evaluating and developing health reform initiatives. Mr. Sheils has also delivered numerous policy briefings to state task forces, federal commissions, private associations and industry representatives on national health policy.

Mr. Sheils has specialized in financial analyses of the impact of health reform proposals at the state and national levels. He directed analyses of the impact on the Patient Protection and Affordable Health Choices Act (PPACA) on payers and providers. He authored the Lewin Group analysis of the cost and coverage impacts of the 2008 presidential candidate's health reform proposals, which was widely quoted in the press. He recently directed analyses of the coverage and cost containment provisions of ten health reform proposals introduced in the US Congress. Mr. Sheils has also assisted several private clients in developing their health reform proposals.

He is currently developing estimates of changes in health plan enrollment under the PPACA at the state, county and health plan levels. He has specialized in the use of microeconomic databases and microsimulation techniques to analyze health, retirement, tax and income maintenance policy issues. He is the architect of the Lewin Group Health Benefits Simulation Model (HBSM). His experience at The Lewin Group includes:

National Health Legislation

- Estimated the cost and coverage impacts of the PPACA signed into law by President Obama. Includes analysis of state and local government spending; private employer costs by firm size, industry, and current insuring status; family health spending by demographic group; and health care providers. The study featured long term impacts estimates through 2029;
- Directed studies comparing the cost and coverage impacts of the House and Senate health reform bills for the Peterson Foundation. Included analyses of the legislation's impact on: federal health spending and revenues and for other stakeholder groups including employers, families, state and local governments and providers;

- Authored analyses of the impact of the American's Affordable Health Choices Act of 2009 on health insurance coverage and spending. This includes an analysis of the original "tri-committee" proposal, which we followed with an analysis of the Energy and Commerce Committee version of the bill. Included analysis of the public plan under the proposal and spending levels under the plan. The study includes estimates of the costs and coverage impacts of the Act for the federal Government, state and local governments, private employers and families.
- Authored the Lewin Group comparison of the 2008 Presidential candidate's health reform proposals on coverage and costs for the federal government and major stakeholder groups. Included estimation of the impact of a "Public Plan" modeled on Medicare, Medicaid expansions, premium subsidy tax credits, high-risk pool proposals and simulation of proposed underwriting rules for the individual and small group insurance markets.
- Assisted U.S. Senators Wyden and Bennett in developing a bi-partisan proposal to reform the U.S. Health care system that would cover all Americans not covered under Medicare (including Medicaid) under a system of competing private health plans, including people now eligible for Medicaid. At this writing, the bill has 14 sponsors in the U.S. Senate including 7 democrats and 7 republicans. Worked with the CBO to assure that the program is fully financed with the income-related premiums for individuals and employers specified in the bill.
- For the Office of The Assistant Secretary for Planning and Evaluation (ASPE), DHHS, developed estimates of the cost and coverage impacts of proposals to expand health insurance coverage including President Bush's tax deduction proposal and the Congressional Tax Credit plan. Included estimation of changes in coverage, federal tax revenues and other stakeholder impacts.
- Directed the Lewin Group analysis of the Commonwealth Fund's health reform proposal presented in "The Path to a High Performance U.S. Health System." Included analysis of changes in payment methodologies designed to create new provider incentives to improve quality while reducing costs. Also included analysis of public health initiatives, funding for health information technology (HIT) and comparative effectiveness research.
- Directed analysis of the coverage provisions of ten congressional proposals to reform the U.S. health care system. These included bills that would expand Medicaid eligibility, eliminate waiting period for Medicare disabled, create a public plan modeled on Medicare, a Medicare buy-in for people age 55 to 64, Medicare for all single-payer models and replacing the tax exclusion for employer health benefits with a tax credit for private insurance.
- Assisted the Federation of American Hospitals (FAH) in developing their recent proposal to reform the U.S. health system. Including analysis of the plans impact on coverage, and costs for major stakeholder groups including the federal government, state and local governments, employers and consumers. Included detailed analyses of the plan's impact on provider revenues.
- Developed a proposal to provide coverage to all children for the Children's Defense Fund (CDF). Included a mandate for all children to have coverage, expansions in SCHIP eligibility and provisions designed to increase enrollment levels among eligible children including: "Express-Lane" enrollment of children in other means tested programs (i.e.,

Food Stamps, WIC, and School lunch programs), 12-month certification, self-declaration of income for children's coverage and elimination of SCHIP premiums and co-payments.

- For Pfizer inc., developed an analysis of the potential impact of proposals to create a federal program to fund research on the comparative effectiveness of alternative health treatments. Included an assessment of medical practice variation, adherence to evidence-based medical (EBM) guidelines and approaches to increase physician compliance with EBM. Included an analysis of how coupling EBM research with strong financial incentives for adherence affects likely net savings.
- Analyzed the cost and coverage impacts of a health reform proposal developed by Dr. Jacob Hacker with the Economic Policy Institute (EPI). Included development of an innovative approach to establish a month-by-month default enrollment process that keys off of private plan enrollment data. Premiums for default enrollment would be paid through the Federal Income tax system and would be set on the basis of the ability pay. Enrollment is automatic during periods without private coverage and does not require individuals to separately apply for coverage.
- Conducted analyses of options to expand health insurance coverage for the Health Care Coverage for the Uninsured (HCCU) group under a Robert Wood Johnson Foundation (RWJF) Grant. Analysis examined combinations of several options including a Medicaid expansion, tax credits, employer tax credits and coverage mandates. Results were provided on an ongoing basis in support of the group's deliberations on reform recommendations.
- Developed estimates of the cost and coverage effects of alternative tax credit proposals for the American Medical Association (AMA) in support of the development of the AMA's health reform proposal. Provided estimates of the impact of 24 alternative health reform models on costs for the federal government, employers and households under alternative proposal to replace the employer health benefits tax exclusion with alternative tax credit models.

State Health Reform Legislation

- In New York for the United Hospital Fund, directed an analysis of several options for expanding insurance coverage in New York State, including mandatory and voluntary approaches to expanding coverage. These included variations on the "Pay-or-Play" model where employers are required to either provide insurance or pay a tax. We also looked at methods to expand coverage in the state through public programs only, such as Medicaid expansions and tax credits. Included development of a detailed accounting of all public and private health spending in the state.
- In Colorado, directed an analysis of several options for achieving universal coverage in the state in support of a Governor appointed commission of public and private stakeholders (i.e., the "208 Commission"). We worked with the authors of four different universal coverage proposals to refine and analyze their impacts. These included a single-payer proposal, Medicaid expansions, employer contribution proposals and health insurance market reforms. Resulted in recommendations and a report describing the key features and impacts of these proposals. The Governor has implemented several of the Commission's recommendations.

- For the Arizona Chamber of Commerce, we estimated the amount of cost-shifting to private payers resulting from under-payments for care provided under Medicaid. This involved a detailed analysis of hospital net revenues by source of payment. Also included an assessment of underpayments for Medicare and the uninsured. Resulted in estimates of the portions of private insurance premiums attributed to shortfalls in payment for the uninsured and public programs.
- For Families USA, developed estimates of the number of people without insurance one or more months over a 24 month period by state. Required reconciling estimates with several federal data sources.
- Estimate the cost and coverage impacts of proposed legislation in Wisconsin that would cover all workers and their families under a program emphasizing a combination of health savings accounts (HSAs) and managed competition to control costs. The client was a consortium of the Wisconsin Health Project, state legislators, the AFL-CIO, and other stakeholder groups in Wisconsin. The bill was ultimately adopted by the state Senate.
- For the Maryland Health Care Commission (MHCC), estimated the impact of adopting the 1993 National Association of Insurance Commissioners (NAIC) small group market model legislation in Maryland. The analysis showed changes in premiums and the number and percentage of firms offering coverage due to changing state laws governing the methods used to set insurance premiums in the Maryland individual and small employer insurance markets.
- For the state of Hawaii, evaluated the impact of a single-payer program for the State. The study emphasized a balanced and non-partisan evaluation of the advantages and disadvantages of adopting such a program. Also included a detailed analysis of health spending in the State and the financial impact of the proposal on major stakeholder groups.
- Evaluated the state's methodology for estimating the impact of Dirigo Health on health spending in Maine for the Maine Chamber of Commerce. Also conducted an independent assessment of the estimates used to set the Dirigo savings offset payment (SOP), which was established to pay for the program. Provided a detailed review of the methods and data used by the state. Included our own review of the available data, and benchmarking the various estimates against other health spending growth estimates in neighboring states.
- Developed a comparison of three options for expanding coverage for children for the California Endowment. Included analyses of proposals introduced by the Governor, AB 772/SB 437 as introduced by assembly men Escutia and Chan, and the New America Foundation. Options modeled included continuous eligibility for children, guaranteed eligibility for managed care enrollees, removal or simplification of the assets test, move from a gross to net income standard, and elimination of certain documentation for applicants.

SELECTED REPORTS AND PUBLICATIONS

"Ideas for Financing Health Reform: Revenue Measures that Also Reduce Health Spending," Statement of John Sheils before the Senate Committee on Finance, May 12, 2009

"The Cost and Coverage Impacts of a Public Plan: Alternative Design Options," Staff Working Paper #4, the Lewin Group, April 26, 2009

"The McCain and Obama Health Care policies: Cost and Coverage Compared," The Lewin Group, October 8, 2008

"A Path to a High Performance U.S. Health System: Technical Documentation," (report to the Commonwealth Fund), The Lewin Group, February 19, 2009

"Impact of an Institute for Clinical Effectiveness on Health Spending: Incentives Matter," (report to Pfizer inc.), The Lewin Group, December 3, 2008

"Updated Cost and Coverage Impacts Analysis for the Healthy Americans Act (HAA) (S.391): The Wyden/Bennett Bill," The Lewin Group, March 11, 2009

"Trends in Coverage and Health Care Costs," Testimony of John Sheils before the Senate Committee on Finance, March 12, 2007

"Opening a Buy-In to a Public Plan: Implications for Premiums, Coverage and Provider Reimbursement," (presentation to Senate Republicans and staff), The Lewin Group, February 11, 2009

"Cost Impact Analysis for the Health Care for America Proposal," (report to the Economic Policy Institute), The Lewin Group, January 30, 2008

"Expanding Health Insurance Coverage for the Near-Elderly," Statement of John Sheils, Senior Vice President, The Lewin Group, Senate Special Committee on Aging, April 3, 2008

"President Obama's Health Care Reform Proposal and Congressional Alternatives," (Keynote address for the Insure the Uninsured Project conference), Sacramento Ca., February 4, 2009

"Estimated Cost and Coverage Impacts of the Universal Health Care Choice and Access Act (S. 1019)," (Senator Coburn's proposal), The Lewin Group, June 3, 2008

"Cost and Coverage Impacts of the President's Health Care Reform Proposal and a Congressional Tax Credit Proposal," (report to The Office of the Assistant Secretary for Planning and Evaluation (ASPE), DHHS), The Lewin Group, February 13, 2008

John Sheils and Randal Haught, "Cost of Tax Exempt Health Benefits in 2004," *Health Affairs*, February 25, 2004

"The Bush and Kerry Health Care Proposals: Cost and Coverage Compared," The Lewin Group, September 21, 2004

"Cost impacts of an Illustrative Coverage Expansion," (prepared for presidential candidate Howard Dean), The Lewin Group, May 12, 2003

"The Health Benefits Simulation Model (HBSM): Methodology and Assumptions," The Lewin Group, February 19, 2009

"Compendium of Cost and Coverage Analyses Provided to the Health Care Coverage for the Uninsured (HCCU) Group," (report to the Robert Wood Johnson Foundation (RWJF)), The Lewin Group, August 2006

"Estimates of the Cost and Coverage Impacts of Proposals to Expand Health Insurance Coverage in New York," (report to The United Hospital Fund and The Commonwealth Fund), August 25, 2006

"Analysis of Hospital Cost Shift in Arizona," (report to The Arizona Chamber Foundation), The Lewin group, March 6, 2009

"People Without Health Insurance at Some Time in 2007 -2008: National and State Level Estimates," (report to Families USA), The Lewin Group, February 18, 2009

"The Wisconsin Health Plan (WHP): Estimated Cost and Coverage Impacts," (report to the Wisconsin Health Project), The Lewin group, June 4, 2007

"Technical Assessment of Health Care Reform Proposals," (report to The Colorado Blue Ribbon Commission for Health Care Reform), The Lewin Group, September 24, 2007

"Expanding Health Insurance Coverage for Small Employers in Maryland with a Reinsurance Program," (report to The Maryland Health Services Cost Review Commission (HSCRC)), The Lewin group, June 30, 2006

"Estimated Cost and Coverage Impacts of Three Proposals to Expand Health Insurance Coverage for Children in California," (report to The California Endowment), The Lewin Group, November 14, 2005

"Impacts of the Escutia/Chan Bill (AB 772/SB 437)," (report to The California Endowment), The Lewin Group, December 23, 2005

SCOTT WITTMAN, JD
CORPORATE DIRECTOR

Educational & Academic Qualifications

Doctor of Jurisprudence, Loyola University of Chicago School of Law (member Illinois Bar)

BA in Political Science and Economics, Knox College

Mr. Wittman is a Director of PHPG. He has 18 years of experience in health care policy evaluation, program development, and financial analysis. His expertise includes analysis of federal laws, regulations, and policies; drafting of state legislation, regulations, and State Plan Amendments; and analysis and development of eligibility requirements, policies, and regulations.

Mr. Wittman has assisted with all facets of Vermont's reform of its Medicaid program through development and implementation of two Section 1115(a) waiver programs – *Global Commitment to Health* and *Choices for Care*. The projects included defining eligibility standards and drafting state regulations in accordance with State objectives and in compliance with federal law and policies. Currently, Mr. Wittman is assisting the State with the extension of both Demonstrations and is reviewing the impact of federal reform on existing eligibility groups and identifying opportunities for revising eligibility criteria.

Mr. Wittman's work on behalf of public sector clients has included:

- Analysis of federal, state and local legislation, regulations, and policies as they pertain to proposed program models;
- Analysis of state legislation, regulations, and policies for consistency and conformity with both federal and other state legislation, regulations, and policies;
- Analysis of historical Medicaid expenditure and utilization data, as well as managed care organization (MCO) encounter data for purposes of developing detailed financial projections to support strategic planning, budgeting and rate-setting activities;
- Evaluation and development of alternative cost sharing and benefit structures and other initiatives, including public-private partnerships and health savings accounts;
- Development of financial models testing the impact of various programmatic, eligibility, and benefit changes;
- Development and implementation of program monitoring tools, including audit guides and performance evaluation guides;
- Development of Section 1115(a) and 1915(b) waiver proposals;
- Development and implementation of operational, clinical, and financial reporting systems;
- Development of contractual performance standards;

- Development of Medicaid reimbursement methodologies and rates for numerous provider types, including hospitals, physicians, nursing facilities, home health agencies and community mental health centers;
- Evaluation and development of long-term care initiatives; and
- Assisting in the development of Medicaid managed care strategies for health maintenance and provider-sponsored organizations.

Background

Prior to joining PHPG in 1994, Mr. Wittman served as a Manager in KPMG Peat Marwick's Government Services Practice, where his duties included evaluation, development, and implementation of health care programs for public sector clients. Prior to joining KPMG, Mr. Wittman worked for the American Hospital Association as a policy analyst.

STEVEN M. LIEBERMAN

EDUCATION

M.Phil., Yale University, 1975 (Political Science)

M.A., University of California, Berkeley, 1973 (Political Science)

B.A., Yale University, *cum laude* and Clark Prize, 1972 (Political Science)

EMPLOYMENT HISTORY

Lieberman Consulting Inc.: President (2007—Present)

Consultant engaged in Medicare, Medicaid and private sector research, policy, data, and budgetary analyses, serving a broad range of providers and provider associations, pharmaceutical and device manufacturers, insurance and managed care companies, trade associations, and the Centers for Medicare & Medicaid Services (CMS). I specialize in applying empirical and economic analyses to inform policy and business issues, such as those involving Medicare reimbursement and coverage.

Visiting Scholar, Engelberg Center for Health Care Reform, Economic Studies Division, The Brookings Institution (2007—Present)

Working with Mark McClellan and as part of the Brookings collaboration with The Dartmouth Institute headed by Elliott Fisher, I have focused on developing Accountable Care Organizations (ACOs). I am co-editing a "user's manual" on ACO implementation, serve as a faculty member for the Brookings—Dartmouth ACO learning network, and provide consulting support to 5 ACO pilot sites. In addition, I have provided policy analysis and developed proposals affecting other Medicare and health reform issues, including competitive bidding for Medicare Advantage plans.

The Moran Company: Managing Partner (2004—2006)

Effective October 1, 2004, joined analytic consulting firm specializing in Medicare, Medicaid and private sector research, policy, data, and budgetary analyses, serving a broad range of providers and provider associations, pharmaceutical and device manufacturers, insurance and managed care companies, and trade associations. Firm specializes in applying empirical and economic analyses to inform policy and business issues, such as those involving Medicare reimbursement and coverage.

CMS: Senior Advisor to the Administrator (2004)

During a 4 month detail, led implementation of Medicare Modernization Act, serving as Executive Director of the CMS MMA Council. Among other responsibilities, coordinated drafting and clearance of proposed regulations implementing the new Medicare prescription drug benefit, retiree drug subsidy for employers, and Medicare Advantage. Developed bidders' data set and policies for employer drug plans.

Congressional Budget Office (CBO): Assistant Director and Executive Associate Director (1999-2004)

Led Health & Human Resources (HHR) Division, with 30+ analysts responsible for analyzing health, social security, long-term modeling and other human resource programs. Directed CBO's analyses of Medicare prescription drug and reform proposals, as well as conducting research on high cost Medicare beneficiaries, regional variations in cost, risk pool size, and partial capitation.

As Executive Associate Director (third ranking official at CBO), concentrated primarily on health and social security issues. Also functioned as Assistant Director for Long-Term Modeling, guiding development at CBO of long-term (75 year) actuarial and micro-simulation models for social security and Medicare. Reorganized Health and Human Resources Division, recruiting new staff and expanding capabilities.

Partner, EOP Group (1998—99) & **President, Lieberman Consulting, Inc.** (1994—97)

Healthcare Consultant for managed care business development and operations, physician practice management, and healthcare reform. Clients include managed care companies, academic health centers, integrated delivery systems, hospitals, physician groups and trade associations. Long-term engagements included:

- Founding Partner, MatureWell, Inc. Raised $15 million in venture capital and created an innovative company focused on integrating acute, long term, and personal care services for the elderly. Designed all MatureWell products, identified market opportunities, and planned strategic positioning of the company.
- Reporting to the Vice Chancellor for Health Sciences at University of California, San Diego (UCSD), served as (line) executive directing 75,000 member managed care network with 1,500 community and academic physicians. Responsibilities included managing 5 group practices and 4 IPAs, payor and provider contracting, marketing, and TPA services (including claims, member services, credentialling, utilization management, quality improvement, and finance). Developed Medicaid HMO.
- Prepared successful "Medicare Choices Demonstration" applications for two Provider Sponsored Networks (PSNs), permitting direct contracting with HCFA on a capitated basis. Implemented PSN at UCSD, allowing beneficiaries direct access to specialists.

Intergroup Healthcare Corporation (IGHC) (1993-1994)

Vice President, Government Programs & Vice President, Marketing. Reporting to CEO, responsible for $500 Million in revenues for 400,000 member managed care company, supervising 7 Directors and budgets of $15 Million. Ran strategic planning, network development, regulatory compliance, and operations of Medicare "risk", Medigap and Medicaid HMOs. Directed marketing and sales for commercial HMO, Medicare, retiree, point of service (POS), preferred provider organization (PPO), and indemnity products. Performed added duties assigned by CEO: negotiated provider contract with 180 physician multi-specialty medical group; designed Medicare "risk" provider contracts; developed rural provider networks; gained Federal HMO qualification and Medicare "risk" contracts in six rural counties; created employer based retiree benefit and managed Workers Compensation products; and re-engineered Marketing and Medicare operations.

Schaller Anderson, Inc. (1992-1993)

Vice President for Strategic Planning and Product Development. Developed Medicare joint venture product. Provided strategic planning for large Medicaid HMO, management consulting for hospital and primary care medical group, and advised clients on health care reform and Medicaid "waivers" in Arizona and nationally.

Office of Management and Budget, Executive Office of the President (1976-1992)

Assistant Director for General Management, 1990-1992. Senior OMB official overseeing ten Federal agencies spending $70 billion. Reporting to the Director and Deputy Director for Management, ran one of eight program areas in OMB. Responsibilities included overseeing the Federal Employees Health Benefits Program and Cabinet-level management consulting. Reorganized and rebuilt the "M" side of OMB.

Health Financing Branch Chief, 1983-1990. Medicare and Medicaid expert responsible for formulation of President's budget, legislative program, and review of regulations, policies, and research. Directed staff of analysts and provided expert advice to senior policy officials. Lead negotiator for Medicare Catastrophic legislation and annual "reconciliation" bills reforming Medicare and Medicaid. Approved all HCFA regulations setting hospital, physician and HMO payment rates, as well as all waivers.

Senior Budget Examiner, 1980-1983. As chief social security analyst, led staff creating pricing models and supporting Director Stockman's work with National Commission on Social Security Reform, resulting in the 1983 Social Security Amendments.

Budget Examiner, 1976-1979. Analyst for social security, supplemental security income (SSI), and other retirement programs.

PROFESSIONAL AFFILIATIONS

Visiting Scholar, Economics Study Division, The Brookings Institution (Engelberg Center for Health Care Reform), 2007—present

Board Member, CareCore National LLC, 2005—present

Board Member, Primary Care Coalition (Montgomery County, Md), 2009--present

Member, National Academy of Social Insurance, 2001—present

Member, Social Security Advisory Board 2007 Technical Panel on Assumptions and Methods, 2006—2007

Fellow, Vanderbilt University Health Care Solutions Group, 2006—2009

United States Government Representative and Vice Chairman, Public Management Committee, Organization for Economic Cooperation and Development (OECD), 1991—92

President's Council on Management Improvement, Executive Committee, 1990—1992

National Health Policy Forum, Steering Committee, 1983-1992; 2000—2004

Chairman, Arizona Rural Health Statewide Advisory Committee, 1996-97

PUBLICATIONS

"Fostering Accountable Care: Moving Forward in Medicare," Elliott Fisher, Mark McClellan, Steven Lieberman, John Bertko, Julie Lee, Julie Lewis, and Jonathan Skinner, Health Affairs 28 no. 2, w219-231 (published online, January 27, 2009).

"Reducing The Growth Of Medicare Spending: Geographic Versus Patient-Based Strategies," Steven M. Lieberman, Julie Lee, Todd Anderson, and Dan L. Crippen. Health Affairs "Web Exclusive" (December 2003).

"Uncertain Spending: Projecting Medicare," Amy Rehder Harris, Steve Lieberman, Noah Meyerson, Michael Simpson, and Joel Smith. Paper presented to the Society of Government Economists Conference at the Allied Social Science Association Meetings, Atlanta, GA. (January 2002).

"Investigating the relationship between Medicare Advantage Enrollment and Spending Projections," Steven M. Lieberman, M.Phil. and Gregory J. Watson, M.S. Poster presented to Academy Health Conference, Seattle, WA. (June 2006).

"Banning Authorized Generics Equals Higher Federal Spending", Donald W. Moran, Steven M. Lieberman, and Kara L. Suter, Letter in Health Affairs (January/February 2008), pp. 302—303.

"The Impact of Authorized Generic Entry During Hatch-Waxman Paragraph IV Exclusivity Periods", Donald W. Moran, Steven M. Lieberman, and Kara L. Suter, www.themorancompany.com (Reports section), March 2007.

SELECTED HONORS AND AWARDS

Social Science Research Council Pre-Dissertation Fellowships (1971 and 1973)

Yale Faculty Research Participation Award (1971—1972)

Northern Ireland Community Relations Council Research Grant (1971—1972)

Clark Prize in Government, Yale College (1972)

Deutsche Akademische Austauschdienst Language Training Award (1973)

Delegate to First German American Young Leaders Conference, American Council on Germany (Hamburg, 1973)

Delegate to Conference of American Council on Germany and Atlantik Bruecke (Bonn, 1974)

Social Science Research Council Dissertation Completion Fellowship (1974—1975)

Brookings Institution Guest Scholar (1974—1975)

Visiting Fellow, International Institute for Management (Berlin, 1975)

Brookings Institution/European Union Fellowship to study Financing and Actuarial Forecasting in European Social Insurance Systems (E.U., 1982)

OMB Director's Young Professional Award (1982)

OMB SES Candidate Development Program (1982—83)

Department of Health and Human Services Award (for role in Medicare Catastrophic Health Insurance, 1987)

GERARD ANDERSON, PH.D.
PROFESSOR
DIRECTOR, CENTER FOR HOSPITAL FINANCE AND MANAGEMENT

RESEARCH AND PROFESSIONAL EXPERIENCE

GERARD F. ANDERSON, PhD is a professor of health policy and management and professor of international health at the Johns Hopkins University Bloomberg School Public Health, professor of medicine at the Johns Hopkins University School of Medicine, director of the Johns Hopkins Center for Hospital Finance and Management, and co-director of the Johns Hopkins Program for Medical Technology and Practice Assessment. He recently stepped down as the National Program Director for the Robert Wood Johnson Foundation sponsored program "Partnership for Solutions: Better Lives for People with Chronic Conditions".

Dr. Anderson is currently conducting research on chronic conditions, comparative insurance systems in developing countries, medical education, health care payment reform, and technology diffusion. He has directed reviews of health systems for the World Bank and USAID in multiple countries. He has authored two books on health care payment policy, published over 200 peer reviewed articles, testified in Congress over 35 times as an individual witness, and serves on multiple editorial committees.

Prior to his arrival at Johns Hopkins, Dr. Anderson held various positions in the Office of the Secretary, U.S. Department of Health and Human Services, where he helped to develop Medicare prospective payment legislation.

HONORS AND AWARDS

Phi Beta Kappa, Haverford College, 1973
Magna Cum Laude, Haverford College, 1973
High Honors in Economics, Haverford College, 1973
University Fellow, University of Pennsylvania, 1974-1977
Fellow of the Fels Center of Government, University of Pennsylvania, 1974-1977
National Health Care Management Fellow, University of Pennsylvania, 1977-1978
Delta Omega Honor Society in Public Health, 1990
Who's Who, 1989 - present
500 Health Policy Leaders - Washington Medicine and Health, 1991 - present
Co-author - Article of Year, Association of Health Services Research, 1995
AHSR Fellow - Association for Health Services Research, 1996 - present

SELECTED PUBLICATIONS

Anderson, G.F. and Chu, E., "Expanding Priorities – Confronting Chronic Disease in Countries with Low Income", New England Journal of Medicine, Vol. 356(3):209-211, January 18, 2007.

Anderson, G.F., "From 'Soak the Rich' to 'Soak the Poor': Recent Trends in Hospital Pricing" Health Affairs, Vol. 26(3):780-789, May/June 2007.

Berkowitz, S.A., Gerstenblith, G., Anderson, G.F., Medicare Prescription Drug Coverage Gap "Navigating the 'Doughnut Hole' With Patients", JAMA, Vol. 297(8): 868-870, February 28, 2007.

Hwang, C.W., Anderson, G.F., Diener-West, M and Powe, N.R., "Co morbidity and Outcomes of Coronary Artery Bypass Graft (CABG) Surgery at Cardiac Specialty Hospitals versus General Hospitals, Medical Care, 2007.

Anderson, G.F., Frogner, B., Johns, R.A. and Reinhardt, U.E., "Health Care spending and Use of Information Technology in OECD Countries", Health Affairs, Vol. 29(3):819-831, May/June 2006.

Anderson, G.F., "Controlling Health Spending: Opportunities for Academic Medical Centers" Academic Medicine, Vol. 81(9); 807-811, September 2006.

Bynum, JP.W., Rabins, P.V., Weller, W., Niefeld, M., Anderson, G.F., Wu, A;, "The Relationalship Between A Dementia Diagnosis, Chronic Illness, Medical Expenditures, and Hospital Use," Research and Practice in Alzheimer's Disease, Vol. 10:160-164, 2005

Anderson, G.F., "Medicare and Chronic Conditions", New England Journal of Medicine,.Vol. 353(3):305-309, 2005.

Wolff, J.L., Boult, C., Boyd, C., Anderson, G., "Newly Reported Chronic Conditions and Onset of Functional Dependency", Journal of Geriatrics Society, Vol. 53: 851-855, 2005.

Snyder, C., Anderson, G., "Do Quality Improvement Organizations Improve the Quality of Hospital Care for Medicare Beneficiaries?" JAMA, Vol. 293(23):2900-2907, June 5, 2005.

Anderson, G.F., Hussey, P.S., Frogner, B., and Waters, H., "Health Spending in the United States and the Rest of the Industrialized World." Health Affairs, Vol. 24(4):903-914, May/June 2005

Waters, H.R., Anderson, G.F., Mays, J., "Measuring Financial Protection in Health in the United States, "Health Policy, Vol. 69:339-349, July/August 2004.

Darer, J.D., Hwang, W., Pham, H.H., Bass, E.B., and Anderson, G.F., "More Training Needed in Chronic Care: A Survey of U.S. Physicians, Academic Medicine, Vol. 79(6):541-548, June 2004.

Fried, L.P., Ferrucci, L., Darer, J., Williamson, J.D. and Anderson, G.F., "Untangling the Concepts of Disability, Frailty, and Comorbidity: Implications for Improved Targeting and Care", Journal of Gerontology: Medical Sciences, Vol. 59(3):255-263, 2004.

Himelhoch, S., Weller, W.E., Wu, A.W., Anderson, G.F. and Cooper, L.A., "Chronic Medical Illness, Depresion, and Use of Acute Medical Services Among Medicare Beneficiaries", Medical Care, Vol. 42(6):512-521, June 2004.

Anderson, G.F., Frogner, B., "Comparative Drug Policies – Heresy Learning From Other Countries, "J. Ambulatory Care Management, Vol 27(3):202-209, 2004.

Anderson, G.F., Horvath, J., "The Growing Burden of Chronic Disease in America", Public Health Reports, Vol. 119(3):263-270. 2004.

Anderson, G.F., Shea, D.G., Hussey, P.S., Keyhani, S., Zephyrin, L., "Doughnut Holes and Price Controls", Health Affairs, July 21, 2004 (Web Exclusive)

Anderson, G.F., Wolff, J., "Meeting Long-Term Care Needs", Advanced Studies in Medicine, Vol. 4(6):318-320, June 2004.

Anderson G., Mahadevia A. "Choosing an Electronic Medical Record", Advanced Studies in Medicine, Vol. 4(8):439-440, September 2004.

Burton L, Anderson G., Kues I. "Using Electronic Health Records to Help Coordinate Care", Milbank Quarterly, Vol. 82:(3):457-481, September 2004.

LANE KOENIG, PHD

EDUCATION

PhD, Economics, University of Maryland, College Park 1999
MA, Economics, University of Maryland, College Park 1993
BA, Economics, University of Florida, Gainesville 1990 (Graduated with Honors)

SUMMARY

Healthcare economist with 13 years of experience in the public and private sectors

- High proficiency in using statistical techniques to study broad range of healthcare issues, including hospital cost efficiency, spending growth, and impact of healthcare interventions.
- Skilled in applying SAS and Excel to develop medical claims and financial databases, conduct econometric analyses, and run microsimulation models.
- Expertise in healthcare systems and provider reimbursement, specializing in Medicare hospital and physician payment policy.
- Excellent interpersonal and project management skills: Successfully managed portfolio of diverse projects valued at $1 million annually, mentored junior staff.
- Effective communicator and public speaker: Regularly briefed Administrator and senior staff at the Centers for Medicare and Medicaid Services, testified before MedPAC.

PROFESSIONAL EXPERIENCE

President, KNG Health Consulting, LLC 2007-Present

- Working with long-term acute care hospital industry to develop LTACH admission criteria
- Critically reviewed Medicaid reimbursement approaches for hospital care in Massachusetts and developed a series of recommendations (subcontractor to Abt)
- Examined the key factors that differentiate high- and low-cost hospitals
- Developed recommendations to reform payments to primary care providers in Vermont. In the second phase, we developed a payment model to support the medical-home concept and a pay-for-performance payment system for diabetes care.
- Modeled alternatives to the Medicare wage index and its impact on hospitals.
- Assessed cost offsets to the Medicare program from the substitution of diagnostic ultrasound for MRI and CAT in diagnosing soft-tissue injuries.
- Evaluated the impact of packaging imaging guidance services under the Medicare outpatient prospective payment system.

- Assisted in implementing an RBRVS for paying physicians under California's workers' compensation system (subcontractor to The Lewin Group)

Senior Economist, The Centers for Medicare and Medicaid Services, Office of the Administrator, Office of Policy 2005 - 2007

- As lead economist for the Office of Policy, assisted in developing CMS responses to external reports and Congressional inquiries on the Medicare Part D program. Frequently briefed CMS Administrator and other senior staff.
- Assisted in analyzing drug prices and beneficiary savings under the Medicare Part D program. Conducted multi-state comparisons of Medicaid and Medicare Part D drug prices and per-capita spending.
- Led development of a model to assess the costs and impact on beneficiaries of alternative CMS policies. Facilitated cross-component meetings with senior staff to build consensus on project approach and direction.

Senior Scientist, The Lewin Group, Health Care Finance Practice 1998 - 2005

- Led numerous health services research efforts, including:
  - Studied the key drivers of expenditures for physician and outpatient services for the Blue Cross and Blue Shield Association
  - Evaluated the costs and benefits of disease management programs using claims data and non-experimental techniques, including matching and regression analysis.
  - Assessed the clinical and economic impacts of care provided in long-term care hospitals using claims data.
  - Conducted analyses to assess the relative cost efficiency of hospitals using hospital cost report data and regression analysis.
  - Evaluated the financial status of teaching hospitals and the cost of graduate medical education using data from the American Hospital Association's Annual Hospital Survey.
- Led efforts to analyze the impact of policies and develop policy options, including:
  - Estimated the cost and appropriate reimbursement level for hyperbaric oxygen therapy under the Medicare outpatient prospective payment system using hospital cost report data, outpatient claims, and hospital survey findings.
  - Developed a financial model of a representative family-physician practice. Simulated the impact on practice costs, revenues, and income to changes in the delivery of care, the types of services provided, and reimbursement policies.
  - Formulated policy recommendations and simulated physician-specialty impacts of adopting a resource-based fee schedule for use in paying providers under California's workers' compensation program.
  - Advised the Centers for Medicare and Medicaid Services on practice expense relative value units for the Medicare Physician Fee Schedule.
  - Simulated the impact of alternatives for a Medicare prospective payment system for long-term care hospitals. Modeled the economic impact of legislation and legislative

proposals -- such as the Balanced Budget Act of 1997 and the Benefits Improvement and Protection Act of 2000 -- on hospitals and physicians.

- Analyzed and modeled payments to hospitals, skilled nursing facilities, and ambulatory surgical centers. Testified before the Medicare Payment Advisory Commission and the Advisory Panel on Ambulatory Payment Classification Groups.

Analyst, Center for Naval Analyses, Medical Team 1997 - 1997

- Developed cost models to calculate the cost of training medical personnel under various assumptions relating to recruitment, pay, and Navy attrition rates.

SELECTED PAPERS

Koenig L. (2008). "Characteristics and Cost Drivers of High-Cost Hospitals." Final reported prepared for the American Hospital Association. November 5, 2008.

Koenig L., White A. (2008). "Payment Methodologies for Inpatient and Outpatient Services Provided in Massachusetts Acute Care Hospitals". Final report by Abt Associates for the Commonwealth of Massachusetts Executive Office of Health and Human Services. October 2008.

Koenig, L. (2008). "An Analysis of Medicare Outpatient Margins of Teaching Hospitals." Final report prepared for the Association of American Medical Colleges. August 24, 2008

Koenig L., Doherty J. (2008). "A Payment Reform Model for the Initial Blueprint Pilots: Final Recommendations." Document prepared for the Vermont Department of Health. April 9, 2008.

Koenig L., Dobson. A. (2008). "Admission Criteria for Long-Term Care Hospitals:

A Review of the Centers for Medicare and Medicaid Services' Work to Date." Report prepared for the National Association of Long-term Hospitals. March 20, 2008.

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Koenig, L., Doherty J., Hearle, K. (2007). "Payment Reform Models to Support the Vermont Blueprint for Health." Document prepared for the Vermont Department of Health. November 1, 2007.

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Mortenson, L., Koenig, L., Rossiter, D., Chan, S., and Dobson, A. (1999). "The Impact of APCs on Hospital Outpatient Cancer Care." Oncology Issues. September/October 1999. Association of Community Cancer Centers. Rockville, MD.

STEVEN J. KAPPEL

EDUCATION

B.S. Communication, Rensselaer Polytechnic Institute, 1974

M.P.A. University of Vermont

Graduate, Vermont Leadership Institute, 2007

SUMMARY

A health care policy and analysis professional, with a broad understanding of all aspects of Vermont's health care system, from financing to outcomes research, combined with significant management experience.

EMPLOYMENT

Policy Integrity LLC, Founder 2007 – Present

Policy Integrity LLC is a consulting firm that assists clients with the development, presentation, and evaluation of policy alternatives in health care and related areas.

***Vermont Joint Fiscal Office**, Associate Fiscal Officer 2000 to 2007*

Provided nonpartisan policy and financial analysis to the Vermont legislature on a wide range of health care and health financing issues, with a particular focus on the Medicaid program. Work with legislators, members of the administration, and the public to develop legislation. Evaluate policy implementation.

Vermont Program for Quality in Health Care, Inc., Executive Director 1998 to 2000

Was responsible for all operational aspects of VPQHC, including finance, personnel, planning, and external affairs, including relationships with legislature and multiple constituencies. Worked with Board to Directors to develop strategies to meet mission. Supervised staff of 6. Managed $500,000 budget. Represented the organization before a wide range of audiences. Wrote or edited publications. Provided leadership in analytical and data management activities. Participated in quality improvement activities.

Department of Banking, Insurance, Securities and Health Care Administration , Director of Analysis and Data Management 1997 to 1998

Directed a 5-person section with broad responsibilities, including development and implementation of health policy, health insurance regulation, development of a statewide health care data base, and analysis of cost, utilization, and outcomes in Vermont's health care system. Developed policy to improve quality and control costs in Vermont's health care system. Advised Department executives, the Governor, and the Legislature. Originated or participated in multi-disciplinary research, including medical outcome, economic, survey, and insurance market reform.

Vermont Health Care Authority, Data Manager 1992 to 1996

Was responsible for financial and utilization analysis in support of health care reform, including development of models for tax and premium-based systems incorporating data from a wide variety of sources including actuarial research and sample data. Worked with a wide range of advocacy groups to develop consensus around economic models. Provided analytical support and testimony to Vermont legislature's Special Committee on Health Care Reform. Worked with health insurers and major employers to develop consensus around a cooperative statewide health care database. Developed a pilot system incorporating claims from Medicare, Medicaid, and two commercial insurers. Designed and implemented a database to manage and analyze Medicare claims information.

BlueCross BlueShield of Vermont, Director of Data Management 1990 to 1992

Directed a department of 5 with an annual budget of $350,000, with responsibilities for database administration, statistical support and computer training. Designed and managed BCBS's end-user information system that provided support for a wide range of clients, from actuarial services to marketing.

BlueCross BlueShield of Vermont, Research and Evaluation Analyst 1987 to 1989

Developed and analyzed statistical reports for a wide audience, including Actuarial, Underwriting, and Health Services. Analyzed and presented utilization reports to customers.

Vermont Department of Health, Senior Research and Statistics Analyst 1985 to 1987

Supervised a 5 member unit which provided statistical support for a wide variety of public health efforts, including epidemiology, health care utilization studies, and population estimation and projection. Designed and developed the statewide hospital discharge information system.

AWARDS

BiState Primary Care Association – Public Service Award, Vermont, 2006

RANDALL HAUGHT
MANAGING DIRECTOR

EDUCATION

B.S., with Honors, Mathematics and Computer Science, Waynesburg College

EXPERIENCE

Mr. Haught joined the Lewin Group in April 1989 as an Associate and is currently a Director. His area of expertise is in data analysis and microsimulation modeling of health care financing and policy related issues. Mr. Haught has nearly 20 years of experience in estimating the impacts of major health care reform initiatives on health spending for households, employers, and various levels of government. Mr. Haught also has extensive experience in Medicare and Medicaid payment policy analysis. His experience includes the following:

Current Projects

- Working with the National Association of Public Hospitals and the American Hospital Association to estimate the impact of the Patient Protection and Affordable Care Act (PPARA) on their member hospitals. The analyses included impact of coverage expansions and Medicare and Medicaid payment modifications.
- Assisted with the Lewin Group's analysis of the House and Senate Leadership health reform bills for the Peter G. Peterson Foundation. The report provides a comparative analysis of the two bills on coverage impacts and 20 year cost impacts on the federal, state and local governments, businesses and households.
- Worked for the HHS ASPE to model the impact of various health care reform options on coverage and Federal costs. These options included variations on the President's health reform plan including individual market rating rules, employer pay-or-play requirements, individual penalty levels for not purchasing coverage, public plan design options, premium and cost sharing subsidy levels, minimum benefit packages and Medicaid expansion levels.
- Assisted with The Lewin Group released of an in-depth assessment of the health care reform policies proposed by the 2008 presidential nominees. The analysis incorporated publicly available information as well as information provided by the campaigns and from interviews with McCain and Obama health policy advisors. The report details the program cost impacts on the federal, state and local governments, businesses and households. The report also provides estimated of the number of people affected by the policies.
- Worked for the Commonwealth Fund to analyze the cost and coverage impacts of eleven health reform plans proposed by various members of the 110th Congress. The analyses were presented in the Commonwealth Fund's report "An Analysis of Leading Congressional Health Care Bills, 2007-2008". The report analyzes and compares leading congressional bills and Administration proposals to expand health insurance coverage introduced over 2007–2008. The Commonwealth Fund commissioned The Lewin Group to estimate the effect of the bills on stakeholder and health system costs and the projected number of people who would become newly insured through them. The proposals fell into

four categories: those that propose fundamental reform of the health insurance system; those that would expand existing public insurance programs; those that would create new options for small employers; and those that would expand HSAs.

- Assisted the Colorado Blue Ribbon Commission on Health Reform in developing alternative proposals to expand health insurance coverage and reform the Colorado health care system. We worked with authors of 5 separate health reform plans to specify, analyze and refine their proposals. Once specified, we used Lewin Group models and data to estimate the cost and coverage impacts of each proposal across various stakeholder groups. The project resulted in a final report showing side-by-side comparisons of the features and impacts of alternative health reform proposals for Colorado, which was presented to the Governor.

- Worked with the American Medical Association to estimate the cost and coverage impacts of their health care reform plan. We assisted the AMA by estimating the reductions in the number of uninsured and cost impacts on various stakeholders including households, employers and various levels of government for more the 20 various options for expanding health care coverage in the U.S.. We developed various metrics to help the AMA compare and assess the various options. The final version of the plan was used in their "Voices for the Uninsured" campaign.

- Assisted with two major health reform proposals now under consideration in the Wisconsin legislature. For the Wisconsin Health Project, The Lewin Group developed a detailed analysis of the impact of the Wisconsin Health Plan (WHP) as specified in the Assembly Bill 1140 (i.e., A.B. 1140). The Lewin Group's role is to provide an objective, non-partisan analysis of the bill on health care costs for major stakeholder groups in the state including governments, employers, families, and providers. Our analyses include: actuarial analyses of proposed benefits packages; simulations of health system impacts; estimates of cost-shifting effects and discounts; and impacts on the state's economy. The Lewin Group also studied the impact of adopting the Wisconsin Health Care Plan (WHCP) sponsored by the Wisconsin AFL-CIO to provide health insurance to all workers and their dependents in Wisconsin. The final reports for these two proposals included a detailed report with an executive summary suitable for use by policy makers.

- Worked with the California Health and Human Services Agency to prepare a detailed analysis of nine widely divergent health care reform proposals, including a single-payer health program, pay-or-play model, and incremental reforms for California. The state selected nine health reform options from among several submitted for consideration by various academics and health policy experts in an earlier state solicitation. The Lewin Group was selected to analyze these proposals and produce a report comparing the key features of these plans and their impact on coverage and costs for key stakeholder groups, including consumers, employers, and federal, state, and local governments. Results of the study were used by the California legislature in designing S.B. 2, which was ultimately signed into law, but repealed in a subsequent referendum.

- Assisted the United Hospital Fund of New York and the Commonwealth Fund developed detailed analyses of several alternative plans to expand insurance coverage in the state. The options analyzed ranged from administrative simplifications designed to increase enrollment in Medicaid and SCHIP, to a requirement for all New York citizens to have coverage with all employers required to contribute to the cost of covering their workers.

We estimated the impact of several program modifications designed to increase Medicaid and SCHIP enrollment of currently eligible people in Medicaid and SCHIP, together with selected expansions in eligibility. We also estimated the impact of these proposals with and without a mandate for people to have health insurance coverage. In addition, we analyzed the impact of combining these policies with a "pay-or-play" requirement for employers that levies a tax on employers who do not offer health insurance.

- Worked for the Commonwealth Fund to analyze the cost and coverage impacts of ten health reform plans proposed by various members of the 109th Congress. The The analyses were presented in the Commonwealth Fund's report "An Analysis of Leading Congressional Health Care Bills, 2005-2007". The report analyzes and compares leading congressional bills and Administration proposals to expand health insurance coverage introduced over 2005–2007. The Commonwealth Fund commissioned The Lewin Group to estimate the effect of the bills on stakeholder and health system costs and the projected number of people who would become newly insured through them. The proposals fell into three categories: those that propose fundamental reform of the health insurance system; those that would expand existing public insurance programs; and those that seek to strengthen employer-based health insurance.
- Developed estimates of the cost of health care reform initiatives and the distributional impacts of these initiatives on health spending for households, employers, and various levels of government for the States of California, Iowa, West Virginia and Vermont under their HRSA State Health Planning Grants. The primary databases used in the HBSM model is AHRQ's Medical Expenditure Panel Survey (MEPS).
- Worked for the Robert Wood Johnson Foundation's Health Coverage 2000 report, which reported cost and coverage impacts of eight proposals to expand health insurance coverage in the United States.
- Worked with the Minnesota Hospital Association to assess Medicaid and Medicare payment rates for Minnesota hospitals. Using cost reports and other data supplied by Minnesota hospitals, Lewin assessed current trends in the payment system, as well as its strengths and weaknesses, and, working with the hospital association, determined possible actions/alternatives to the current payment system.
- Worked with the Kentucky Hospital Association to assess the level of Medicaid payment rates for Kentucky hospitals and to assess the Medicare-type DRG system recently implemented by the Medicaid Department. Using claims data, hospitals cost report data and other data supplied by Kentucky hospitals, Lewin assessed the adequacy of the Medicaid payment rates for Kentucky hospitals relative to payment levels in neighboring State Medicaid programs. Lewin evaluated the equity of payment rates across hospitals in the state under the new Medicaid DRG system. Work with the Kentucky Hospital Association, some of our recommended modifications were adopted by the State in order to make the payment system more equitable across the states' hospitals.
- Worked with the Pennsylvania Legislative Budget and Finance Committee to examine the adequacy of Medicaid hospital payment rates in the state. The study included an in-depth financial analysis of the State's hospitals including measuring Medicaid payment to cost ratios of the hospitals. Results of the study were presented to the Pennsylvania Legislative Budget and Finance Committee.

- Worked with the American Hospital Association to analyze the financial impact on the nation's hospitals under the Medicare hospital payment provisions under the Balanced Budget Refinement Act and The Medicare and Medicaid Benefits Improvement Act. The project utilized data from the AHA's Annual Survey of Hospitals, Medicare Hospital Cost Reports, and other hospital payment system data available through CMS.

Publications

Allen Dobson and Randall Haught, "The Rise Of The Entrepreneurial Physician", *Health Affairs* Web Exclusive, October 25, 2005

John Sheils and Randall Haught, "The Cost Of Tax-Exempt Health Benefits In 2004", *Health Affairs* Web Exclusive, February 25, 2004

Allen Dobson, Randall Haught and Namrata Sen, "Specialty Heart Hospital Care: A Comparative Study", *The American Heart Hospital Journal*, Premiere Issue, Winter 2003.

John F. Sheils and Randall Haught, "The Public Cost of Expanding Coverage", *Health Affairs*, Special Supplement, Spring 1995.

John F. Sheils and Randall Haught, "Alternative Estimates: No Pain, No Gain", *Health Affairs*, Special Supplement, Spring 1994.

John F. Sheils and Randall Haught, "Potential Public Expenditures Under Managed Competition", *Health Affairs*, Special Supplement, Spring 1993.

Randall Haught and Allen Dobson, "An Analysis of Pennsylvania Medical Assistance Payments as it Relates to the Financial Health of Pennsylvania Hospitals", Final Report to the Pennsylvania Legislative Budget and Finance Committee, March 7, 2001.

John F. Sheils and Randall Haught, "The Financial Impact of the Health Security Act", The Lewin Group, December 9, 1993.

John F. Sheils and Randall Haught, "Medicare Reform Options: Change in Private Coverage And Household Spending", Final Report to the Progressive Policy Institute, February 14, 1996.

John F. Sheils and Randall Haught, "The Impact of Alternative Small Group Reform Proposals on Coverage and Household Health Spending", January 30, 1996.

John F. Sheils and Randall Haught, "The Cost of Legislative Restrictions on Contracting Practices: The Cost to Governments, Employers, and Families", Health Care Leadership Council, June 21, 1995.

John F. Sheils and Randall Haught, "Changes in Medicare Program Spending under Alternative Medical Savings Account Models", The National Committee to Preserve Social Security and Medicare, September 22, 1995.

John F. Sheils and Randall Haught, "Managed Care in Missouri: The Impact on the Health Care System and the Economy", The Missouri Department of Health, March 26, 1996.

THOMAS P. CARLSON
MANAGING DIRECTOR

EDUCATION

Masters of Arts in Economics, UCLA

Bachelors of Science in Economics, University of Minnesota

PROFESSIONAL

Fellow in The Society Of Actuaries

Member of The American Academy of Actuaries

EXPERIENCE

Thomas Carlson is a Managing Director at the Lewin Group. Mr. Carlson's has 16 years of actuarial consulting experience in a variety of settings. Recent work has centered on the provision of actuarial services and Medicaid program operations and policy. He has extensive experience analyzing state and federal health policy, evaluating Medicaid initiatives, and providing technical assistance for capitating commercial and government health care programs. Recent experience includes the following projects:

- Worked with multiple Blue Cross Blue Shield plans to determine an optimal range of surplus for the plans to ensure financial viability and ongoing vitality. Surplus ranges were determined based on financial projections as well as historical precedents of similar Blue plans, and project work included expert testimony to insurance regulators.
- Assisted the State of Colorado with the calculation of trend, Incurred but Not Reported (IBNR), Policy Changes, Fee Schedule Adjustments, and actuarial certification of the final rates used in the acute care, behavioral health care, and PACE Managed Medicaid programs. These programs cover Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI) and Foster Care populations.
- Assisting in the calculation of capitation rates for West Virginia's mandatory Medicaid managed care program, Mountain Health Trust. Tasks include calculating the base per member, per month (PMPM) costs, analyzing utilization data, calculating regional adjustment factors, and deriving trend factors to calculate capitation rates. Other tasks include assessing the impact of changes in payment rates on participating HMOs and the impact of recent case mix changes on the capitation rate. Finally negotiations and discussions with the State, CMS and the participating health plans regarding the rate setting processes and possible modifications to the process in the face of the changing environment.
- Developed and certified fully capitated rates for the State of South Carolina's Medicaid managed care program including Temporary Assistance for Needy Families (TANF) and Supplemental Security Income (SSI) aid categories and special payment methodology for delivery and newborn cases. Rates are risk adjusted for plan experience vis-à-vis fee-for-service experience. Calculated rates using raw claims data received on 3490 tapes and imported into databases for summary and analysis. Adjustments applied include Incurred but Not Reported (IBNR), managed care eligibility calculations, large claims analysis, and

newborn reinsurance carve-out. This experience is directly applicable to the proposed project in Delaware. 2002 – 2006.

- Calculated and certified capitated rates for an expansion of the STAR+PLUS program in Texas. STAR+PLUS covers the ABD population with the expansion increasing coverage from Harris County to other large urban areas of the State. The expansion carved out inpatient hospital services, however the contract for the program included incentives and penalties based on the management of inpatient services. This work is directly applicable to the project in Delaware. 2005 – 2006.
- Delivered pricing scenarios for the State of Illinois healthcare expansion, including costs by various eligibility cohort, variations in benefit design, implementation timeline and employer healthcare assessment modeling. We worked with a team from multiple state agencies including the Governor's office, the Department of Insurance, the Department of Revenue and Medicaid to coordinate state functions. 2006 - 2007
- Calculated rates and waiver costs for implementing a consumer directed health program for South Carolina's proposed 1115 waiver. Mr. Carlson assisted the State with the calculation of rates, benefit designs, assumptions used to calculate the benefits and projections involving the carry-forward of account balances. 2005 - 2006
- Worked with Texas and South Carolina on acute care and transportation waivers' cost effectiveness. This work entailed filling out the appropriate form, Appendix D, as required by CMS. 2004 - 2006
- Assisting the Detroit Wayne County Community Mental Health Agency in implementing a Medicaid managed care program for persons with developmental disabilities, severe mental illness, or severe emotional disability to comply with Michigan's 1915 (b)(c) waiver. Mr. Carlson helped the Agency work with the newly formed networks which would serve the recipients in the program, created a prepaid model for the reimbursement including reinsurance for the new networks. 2002 - 2003
- Calculating and certifying the daily psychiatric rehabilitation treatment facility (PRTF) rate for the State of Colorado in their program. The rate accounts for more stringent requirements with respect to the clinical component of care. 2005
- Delivered disease management procurement services to South Carolina's Medicaid program. This included running selection criteria, answering bidders' questions, and developing the reconciliation process. 2004
- Assisting the State of Texas recalibrating relative DRG weights and base rates (Standard Dollar Amount). Updated hospital-specific DRG Standard Dollar Amounts with 2004 Medicare cost report data, and adjusted for administration and capital levels in Medicare cost reports. Calculated regional relative weights using Medicare values when credible samples were not available. 2005 - 2006
- Worked with South Carolina on developing actuarially sound rate ranges, allowing State procurement of services based on geographical areas. 2005
- Worked with South Carolina's Medically Fragile Children program to develop actuarially sound rate ranges, as required by CMS for this capitated program.2005

- Delivered an issue paper for the State of Texas explaining the problems with uncompensated care reporting. The paper estimates the cost of uncompensated care in Texas by considering the reported charges, converting charges to estimated costs, and then removing revenue streams which pay for uncompensated care. 2006
- Analyzed financial projections for numerous M & A engagements. Typically examining multi-year reserving calculations to determine if they were being done consistently to give a true estimate of current earnings before interest, taxes, depreciation, and amortization. 2003 – 2006

W. PETE WELCH, PH.D.
SENIOR CONSULTANT – THE LEWIN GROUP

EDUCATION

Ph.D., Economics, University of Colorado

B.A., Economics, Swarthmore College

EXPERIENCE

W. Pete Welch, Ph.D., is a Senior Consultant at The Lewin Group. Dr. Welch combines analytic skills with hands-on experience in a managed care organization (MCO). In addition to working for a regional MCO for three years, he worked at the Urban Institute for almost a decade, was research director of a trade association, taught at the University of Pittsburgh, and had two stints in government (Office of Management and Budget (OMB) and Congressional Budget Office (CBO)).

Dr. Welch has published more than fifty articles in peer-reviewed journals - including a number in both Health Affairs and New England Journal of Medicine - and was on the editorial board of Medical Care Research and Review for a decade. He is especially knowledgeable about MCOs, physician payment, and drug claims. In 1990 he was part of the team that developed the geographic cost-of-practice index that is still used to adjust Medicare payments to physicians. He later was a member of the White House Health Reform Task Force.

Geographic Variation

- Managed Care Organizations (MCOs): Explored alternative geographic adjustors to Medicare's payment to MCOs (HCFA Review). One of those adjustors was incorporated into Balanced Budget Act of 1997.
- Physicians: Helped develop the geographic cost-of-practice index that was incorporated into the Medicare fee schedule for physicians in 1992 (J Health Economics).
- Physicians: Analyzed the geographic variation in physician services, which was disaggregated into inpatient services per admission and outpatient services per capita (NEJM).
- Physicians: Directing a project for the California Workers' Compensation Program on implementing a resource-based relative value scale for paying physicians. Two geographic policy options are analyzed: using the Medicare geographic practice cost index (GPCI) to adjust payment by metropolitan area and making an add-on payment in health professional shortage areas.
- Post-Acute Care Providers: Analyzed the geographic variation in home health utilization, finding a much higher coefficient of variation than for physicians and hospitals (NEJM).

Other Medicare Payment Issues

Has more than twenty years of experience working on Medicare payment issues, involving most of the major categories of providers. Able to quickly grasp the details of CMS regulations.

- Led team that developed detailed proposal on Medicare payment for inpatient physician services (multiple peer-reviewed articles). Proposal was incorporated into the President's proposed budget in 1995.
- Analyzed the post-hospital-discharge spending and whether such services could be bundled into hospital payment (Health Affairs).
- Across Provider Types: Integrated overall Medicare spending (per Dept. of the Treasury) and claims files to create a set of expenditures figures that facilitated drill-down to detailed categories (Health Affairs). In the process, found a $1 billion accounting error involving payment to SNFs for outpatient rehabilitation services under Part B.

Electronic Health Records

- Performed the first multi-practice analysis of the impact of electronic health records on quality and cost of care (*JAMIA, 2007*). The study used physician and pharmacy claims to measure adherence to clinical guidelines by enrollees with chronic conditions. Site visits were conducted at all four practices.

Analysis of Administrative Data

During twenty years of working with health care claims data, has worked with a variety of file types in a variety of organizational settings.

- At The Urban Institute, extensively used Medicare Standard Analytic Files (SAF).
- At CBO, arranged for regular importation of SAF files, which CBO continues to use to estimate the budgetary impact of specific pieces of legislation.
- At a regional MCO, developed a data mart of drug claims. Checked plausibility data elements (e.g., NDC code, formulary status, days supply) and internal consistency of dollar amounts (e.g., ingredient cost, dispensing fee, copayment). Merged claims-level file with employment group-level file (copayment amounts varied by group).
    - At the MCO, daily used Oracle SQL to manipulate administrative data for operational purposes. Experienced in ferreting out procedures used to create data for operational purposes.
- At UnitedHealth Group, one of the largest private insurers in the country, used to its data warehouse for two AHRQ-funded projects.
    - In a third AHRD-funded project, evaluated state-of-the-art of the Medicaid Analytic eXtract (MAX) in a report to AHRQ, based in part on extensive discussions with key CMS staff members. Used CMS' State Summary File (a data mart made available to state Medicaid agencies) to investigate the completeness of selected data for beneficiaries in MCOs.

PUBLICATIONS

Recent Publications

W. Pete Welch, Dawn Bazarko, Kimberly Ritten, Yo Burgess, Robert Harmon, and Lewis G. Sandy, "Electronic Health Records in Four Community Physician Practices: Impact on Quality and Cost of Care," J Am Medical Informatics Assn, May/June 2006, 14:320-328.

W. Pete Welch, Barbara Rudolph, Lynn A. Blewett, Stephen T. Parente, Cindy Brach, Denise Love, and Robert Harmon, "Management Tools for Medicaid and State Children's Health Insurance Program (SCHIP)," J of Ambulatory Care Management, Oct/Dec 2006, 29:272-282.

MCOs

W. Pete Welch (2002) "Outpatient Encounter Data for Risk Adjustment: Strategic Issues for Medicare and Medicaid," J of Ambulatory Care Management 25 (July): 1-15.

W. Pete Welch, Chris Bergsten, Charles Cutler, et al. (2001) "Disease Management Practices of Health Plans," American J of Managed Care 8 (April): 353-361.

W. Pete Welch (2000) "Does Risk Adjustment for Medicare Patients Reward Caring for Sick Patients or Liberal Admission Practices?" Effective Clinical Practice 3 (May/June): 147-152.

W. Pete Welch (1997) "Commentary [on 'Expenditure Models for Prospective Risk Adjustment: Choosing the Measure Appropriate for the Problem']," Medical Care Research and Review 54 (June): 144-147.

W. Pete Welch and H. Gilbert Welch (1996) "Fee-for-Data: A Strategy to Open the HMO Black Box," Health Affairs 14 (Winter): 104-116.

W. Pete Welch (1996) "Growth in HMO Share of the Medicare Market, 1989-1994," Health Affairs 15 (Fall): 201-214.

W. Pete Welch and Martcia Wade (1995) "The Relative Cost of Medicaid Enrollees and the Commercially Insured in HMOs: Implications for Reform," Health Affairs 14 (Summer): 212-223.

W. Pete Welch (1994) "HMO Market Share and Its Effect on Local Medicare Costs," in HMOs and the Elderly, H. S. Luft (ed.), Health Administration Press: Ann Arbor, MI.

W. Pete Welch (1992) "Alternative Geographic Adjustments in Medicare Payment to Health Maintenance Organizations," Health Care Financing Review 13 (Spring): 97-110.

Alan L. Hillman, W. Pete Welch, and Mark V. Pauly (1992) "Contractual Arrangements Between HMOs and Primary Care Physicians: Three-Tiered HMOs and Risk Pools," Medical Care 30 (February): 136-148.

W. Pete Welch (1991) "Defining Geographic Areas to Adjust Payments to Physicians, Hospitals, and HMOs," Inquiry 28 (Summer): 151-160.

W. Pete Welch, Alan L. Hillman, and Mark V. Pauly (1990) "Toward New Typologies for HMOs," Milbank Quarterly 68 (2): 221-243.

W. Pete Welch (1990) "Giving Physicians Incentives to Contain Costs Under Medicaid," Health Care Financing Review 12 (Winter): 103-112.

W. Pete Welch (1989) "Improving Medicare Payments to HMOs: Urban Core Versus Suburban Ring," Inquiry 26 (Spring): 62-71.

W. Pete Welch and Mark Miller (1988) "Mandatory HMO Enrollment in Medicaid: The Issue of Freedom of Choice," Milbank Quarterly 66 (4): 618-639.

W. Pete Welch (1988) "HMO Enrollment and Medicaid: Survival Analysis with a Weibull Function," Medical Care 26 (January): 45-52.

W. Pete Welch (1987) "The New Structure of Individual Practice Associations," Journal of Health Politics, Policy and Law 12 (Winter): 723-739.

W. Pete Welch (1986) "The Elasticity of Demand for HMOs," Journal of Human Resources 21 (Spring): 252-266.

W. Pete Welch and Richard G. Frank (1986) "The Predictors of HMO Enrollee Populations: Results From a National Sample," Inquiry 23 (Spring): 16-22.

Richard G. Frank and W. Pete Welch (1985) "The Competitive Effects of HMOs: A Review of the Evidence," Inquiry 22 (Summer): 148-162.

W. Pete Welch (1985) "Health Care Utilization in HMOs: Results from Two National Samples," Journal of Health Economics 4 (Winter): 293-308.

W. Pete Welch (1985) "Regression Toward the Mean in Medical Care Costs: Implications for Biased Selection in Health Maintenance Organizations," Medical Care 23 (November): 1234-1241.

W. Pete Welch (1985) "Medicare Capitation Payments to HMOs in Light of Regression Toward the Mean in Health Care Costs," in R.M. Scheffler and L.F. Rossiter (eds.), Advances in Health Economics and Health Services Research, Vol. 6 (Greenwich, CT: JAI Press).

W. Pete Welch, Richard G. Frank, and Paula Diehr (1984) "Health Care Costs in Health Maintenance Organizations: Correcting for Self-Selection," in R.M. Scheffler and L.F. Rossiter (eds.) Advances in Health Economics and Health Services Research, Vol. 5 (Greenwich, CT: JAI Press).

W. Pete Welch (1984) "HMO Enrollment: A Study of Market Forces and Regulation." Journal of Health Politics, Policy and Law 8 (Winter): 743-758.

Physician Services

Latimer, Eric A., Diana Verrilli, and W. Pete Welch (1999) "Utilization of Physician Services at the End of Life: Differences Between the U.S. and Canada," Inquiry 36 (Spring): 90-100.

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EVELYN MURPHY, J.D., M.PL.
SENIOR CONSULTANT

EDUCATION

Master's in Health Planning, Indiana University School of Public & Environmental Affairs, Indianapolis, Indiana, USA (1999)

Doctor of Jurisprudence, Indiana University School of Law, Indianapolis, Indiana, USA (1992)

Bachelor of Arts, St. Mary-of-the-Woods College, Terre Haute, Indiana, USA (1989)

EMPLOYMENT HISTORY

2005-Current Senior Consultant—The Lewin Group

- Research clinical guidelines and industry practice in models of care and provider network in Special Needs Plans
- Provide consultation to states on Medicaid managed care programs, including member satisfaction survey, federal waivers and amendments, managed care readiness reviews
- Assist health plans develop Medicaid managed care proposals
- Assist public sector clients develop health care reform proposals

2003-2005 Private Consultant—Health Care

- Conducted research and wrote reports on the healthcare safety net and funding for the uninsured and under-insured populations in Indiana
- Surveyed Indiana local health department and reported on emergency preparedness
- Prepared federal grants on behalf of state agency
- Provided technical assistance to mental health centers on strategies for minority and women's enterprise business development

2001-2003 Director, Long Term Care Operations, Office of Medicaid Policy and Planning, Indiana Family and Social Services Administration

- Managed the Medicaid long term care operations for the Office, which include nursing facility services and payment, hospice benefit, Medicaid buy-in for individuals with disabilities, and home health services.
- Developed and implemented cost containment strategies saving $50 million over biennium
- Managed development and implementation of new 1915(c) home and community-based waivers and amendments and state plan amendments
- Provided fiscal and program impact analysis of various long term care proposed state laws

- Maintained formal relationships with federal, state and local officials, consumer advocacy groups and provider trade associations

1998-2001 Assistant Deputy Director, Division of Mental Health and Addiction, Family and Social Services Administration

- Evaluated feasibility of mental health managed care in Indiana
- Managed procurement, and negotiated and drafted provider and consultant contracts
- Maintained formal relationships with federal, state and local officials, consumer advocacy groups and provider trade associations

1996-1998 Managed Care Policy Analyst, Office of Medicaid Policy and Planning

- Developed and implemented Medicaid managed care policies and managed care organization (MCO) procurement
- Coordinated External Quality Review Organization contractor work (including managed care organization readiness reviews, focused clinical studies, and ongoing quality assurance activities)
- Provided fiscal and program impact analysis of various managed care proposed state laws

1989-1993 Staff Attorney, Family and Social Services Administration

- Served as legal advisor for the Division of Disability, Aging and Rehabilitative Services
- Presided over beneficiary appeals as administrative Law Judge for Social Security Disability determinations (1995-1996)

PROFESSIONAL & COMMUNITY INVOLVEMENT

1992-Current - Member of Indiana Bar

SELECTED PUBLICATIONS AND PRESENTATIONS

Lewin project reports are published at www.lewin.com. Below are is selection of reports and presentation.

Amy Herr, Kathy Kuhmerker and Evelyn Murphy, Recommendations for Minnesota's Personal Assistance Program, prepared for the Minnesota Department of Human Services, July 2009.

Association for Community Affiliated Plans CEO Summit panel, "Out of Network Payment Issues: How Big a Problem is This and What Can Plans Do To Fix It?" July 14, 2009, Washington, D.C.

Joel Menges and Evelyn Murphy, "Medicaid Non-Emergency Out-of-Network Payment Study," prepared for Medicaid Health Plans of America and Association for Community Affiliated Plans, July 13, 2009.

Randall Haught, Evelyn Murphy and John Sheils, "Cost and Coverage Impacts of Five Proposals to Reform the Colorado Health Care System," prepared for the Colorado Blue Ribbon Commission for Health Care Reform, December 29, 2007.

Appendix B:
Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Governments, Employers, Families and Providers, Executive Summary

The LEWIN GROUP®

Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Governments, Employers, Families and Providers

Staff Working Paper # 11

Date: June 8, 2010

Executive Summary

In this study we provide estimates of the cost and coverage impacts of the Patient Protection and Affordable Care Act (PPACA). We estimate the program's impact on sources of health insurance coverage and spending for the federal government, state and local governments, private employers, consumers and providers. We estimated the impact of the Act over a 10 year period from 2010 through 2019, which is consistent with the "budget window" used by the Congressional Budget Office (CBO). However, we also provide estimates for 2020 through 2029.

We developed these estimates using the Group Health Benefits Simulation Model (HBSM) developed by the Lewin Group. Our revenue and spending estimates over the 20-year period reflect the actual phase in of coverage provisions and expected lags in enrollment for newly eligible people. However, to illustrate the program's impact on sources of coverage and family spending, we present estimates assuming that Act is fully implemented and that enrollment has fully matured in 2011.

The Act

The PPACA requires most Americans to have health insurance. To assure access to affordable coverage, the Act expands the Medicaid program to cover all low-income adults living below 133 percent of the federal poverty level (FPL). The Act also provides a new premium subsidy program for people living below 400 percent of the FPL ($88,000 for a family of four).

The Act also provides a small employer health insurance tax credit for the employer's first two years of providing coverage. The credit is available to firms with fewer than 25 workers with an average employee payroll of less than $50,000. The Act also creates a temporary reinsurance program for employer sponsored retiree benefits, although the program includes only enough funding for two to three years operation.

The centerpiece of the Act is a newly established "exchange" that presents consumers with a selection of health coverage alternatives. The exchange will be available to individuals and firms with fewer than 100 workers, although the state has the option to extend the exchange to larger firms beginning in 2017. Only people participating in the exchange who do not have access to qualifying employer coverage will be eligible for the premium subsidies. The Act also reforms insurance markets by assuring guaranteed issue of coverage, limiting premium variation by age and prohibiting premium variation by health status.

The PPACA creates penalties for both employers with uncovered workers and individuals who do not have coverage.

- **Employer penalties:** Non-insuring employers with more than 50 workers pay a penalty if one or more of their workers obtain premium subsidies in the exchange. The penalty amount is equal to the lesser of $3,000 for each full-time worker receiving a premium credit, or $2,000 for each full-time worker; and
- **Individual penalties:** The Act imposes a penalty on uninsured individuals equal to the greater of $695 and 2.5 percent of income, not to exceed $2,085.

The Act is funded with reductions in spending under Medicare and additional federal tax revenues. The Act creates a new excise tax on high cost health plans (premiums over $10,200 for individuals and $27,500 for families). It also includes a second excise tax on health insurance, and new excise taxes on branded prescription drugs and device manufacturers.

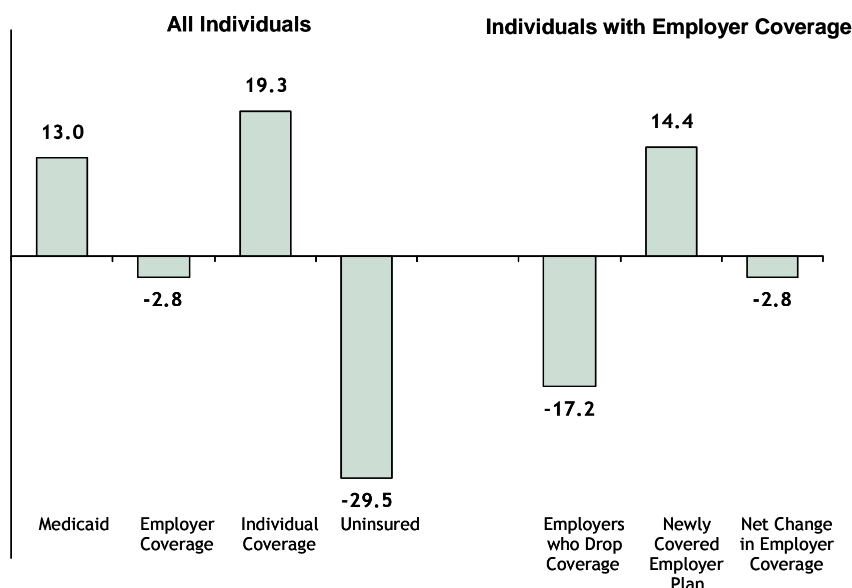
The federal government pays all of the cost of the expansion in Medicaid through 2016. A state matching requirement of 10 percent is phased-in by 2019. The Act increases the Federal Medical Assistance Percentage (FMAP) for the Children's Health Insurance Program (CHIP) by 23 percentage points, up to a maximum of 100 percent.

Coverage

The expansions in coverage are first implemented in 2014, and are not expected to reach full enrollment until after 2016. Thus, to illustrate the impact of the Act on coverage, we estimated the changes in coverage assuming the program is fully implemented in 2011 and that enrollment is fully matured in that year. We project that there will be 49.1 million uninsured in 2011 under prior law. Changes in coverage include:

- The Act would reduce the number of uninsured by 29.5 million people (***Figure ES-1***);
- Roughly half of those who remain uninsured are people exempt from the mandate such as undocumented immigrants, very low income people, and those who are exempt because they would have to pay a premium in excess of 8 percent of income;

Figure ES-1
Changes in Sources of Coverage under the Act Assuming Full Implementation in 2011 (millions) [a/]



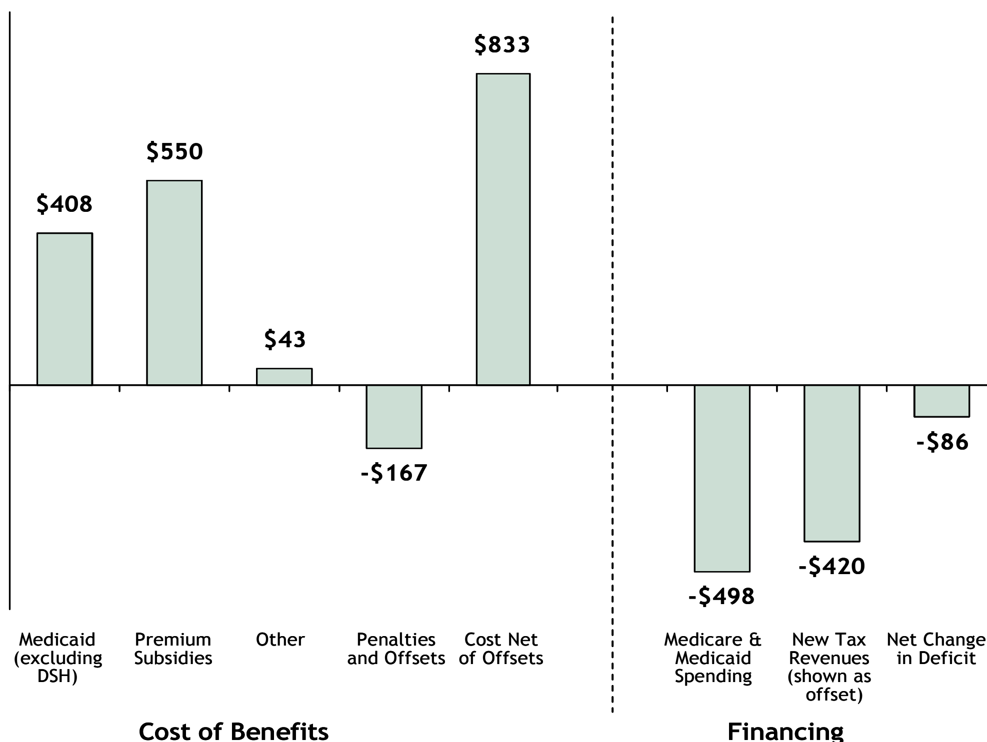
a/ For illustrative purposes, we assume that the program is fully implemented and enrollment is fully mature in 2011.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

- Medicaid and CHIP enrollment will increase by 13.0 million people;
- The number of people with employer-sponsored insurance will decline by about 2.8 million people:
  - About 17.2 million people are in firms that will drop their coverage once their workers become eligible for subsidized coverage in the exchange; and
  - About 14.4 million people are in non-insuring firms that will decide to offer coverage to avoid the penalty.
- The number of people with individually purchased private coverage will increase by 19.3 million people, which more than doubles the number of people covered under the individual market.

Federal Costs

Our analysis shows that the Act will reduce the federal deficit by $86 billion over the 2010 through 2019 period and will reduce the deficit by an additional $389 billion in the following decade (***Figure ES-2***). Revenues and expenditures for the 2010 through 2019 period include:

Figure ES-2
Federal Costs and Revenues under the Act: 2010-2019 (billions)



- a/ Congressional Budget Office (CBO).
  Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

- Total new benefits costs will be $408 billion for the Medicaid expansion, $550 billion for the premium subsidy program and another $43 billion for the employer tax credit and other provisions of the Act;
- There will be program offsets of $167 which includes employer and individual penalty payments for people who do not have coverage and revenues from the excise tax on high cost plans;
- About half of program costs will be funded with reductions in payments to providers and health plans under the Medicare and Medicaid programs, which the CBO estimates will amount to $498 billion over the ten year period;
- The Act includes about $420 billion in new tax revenues. These include including new excise taxes on insurance, branded prescription drugs and medical devices; and
- New revenues also include an increase in the Medicare Hospital Insurance tax rate of 0.9 percentage points for people with incomes over $250,000.

State and Local Governments

We estimate that over the 2010 through 2019 period, state and local governments will save $107 billion, primarily due to savings in safety-net programs serving the uninsured. These ten-year effects include:

- State Medicaid spending will decline by about $39 billion even though states will eventually pay about 10 percent of the cost of the expansion. This is because the Act:
  - Increases the federal matching percentage for CHIP by 23 percentage points; and
  - Increases the federal matching percentage to 90 percent by 2019 for people in newly eligible groups that are already covered by the state Medicaid program (e.g., non-custodial adults).
- We estimate savings of about $100 billion for safety-net programs, such as public hospitals and free clinics, as the number of uninsured declines; and
- Health benefit costs for state and local government workers over the 2010 through 2019 period will increase by $35 billion due to the cost of penalties for uninsured workers.

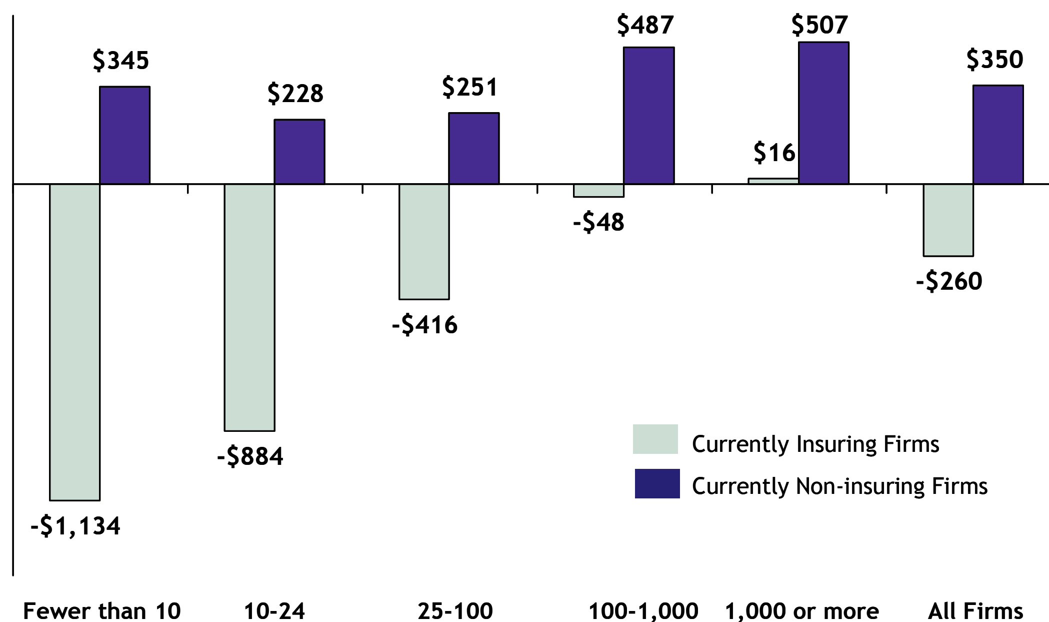
Private Employers

The Act requires all but small employers to pay a penalty for uninsured workers. As discussed above, it also establishes incentives that will cause some employers to discontinue coverage while encouraging others to begin offering insurance. The Act also provides tax credits to lower-wage firms with fewer than 25 workers for the purchase of coverage.

- Currently insuring firms will save an average of $260 per worker per year under the Act, primarily because some employers of lower-wage workers will discontinue their health plans once subsidized coverage becomes available to uninsured workers under the Act (***Figure ES-3***);

- Costs for firms that do not now offer coverage will increase by an average of about $350 per worker under the Act, reflecting the cost of either providing insurance or paying the penalty;
- Small insuring firms will save up to an average of about $1,100 per worker due to the health insurance tax credit for small employers; and
- Private employer health spending over the 2010 through 2019 period will decline by $55 billion over the 2010 through 2019 period, but will increase by $373 billion in the following decade.

Figure ES-3
Change in Private Employer Health Spending Per Worker under the Act if Fully Implemented in 2011



- a/ For illustrative purposes, we assume that the program is fully implemented and enrollment is fully mature in 2011.
  Source: The Lewin Group estimates using the Health Benefits Simulation Model.

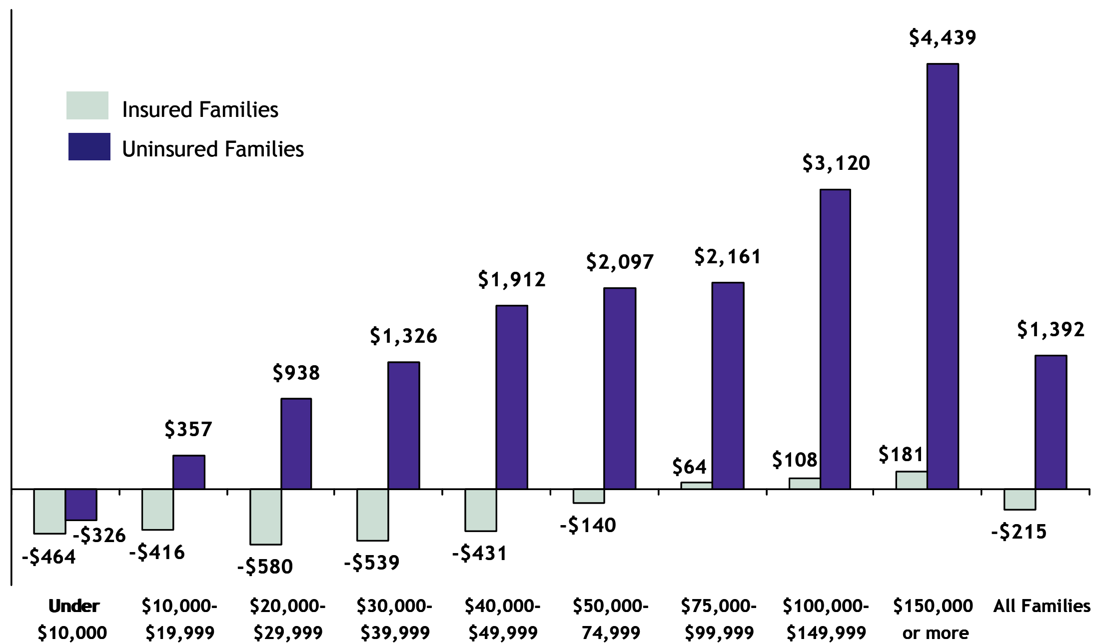
Impacts on Families

Under prior law, families would have spent an average of about $4,193 per family for health care in 2011. This includes average family premium payments of $2,648, including employee contributions to employer coverage. It also includes average out-of-pocket expenses for insurance co-payments and uncovered health services of $1,545.

- If fully implemented in 2011, health spending will increase by about $86 per family under the Act;
- Currently insured families with income below $50,000 will see savings averaging roughly $500 per family (***Figure ES-4***); and

- Families with uninsured members will see an increase in family health spending of $1,392 per family under the Act.

Figure ES-4
Changes in Average Family Health Spending under the Act if fully implemented in 2011[a/]



- a/ For illustrative purposes, this scenario assumes that the Act is fully implemented and enrollment is fully matured in 2011.
- Source: The Lewin Group estimates using the Health Benefits Simulation Model.

Impact on National Health Spending

National health spending will reach $2.77 trillion in 2011. This includes payments for all health care providers by all public and private payers and households. Health spending under the Act will increase throughout the next two decades.

- Total national health spending under the Act will increase by about $218 billion over the 2010 through 2019 period and an additional $344 billion in the following decade;
- Most of the increase in spending will be attributed to increased utilization of health services by newly insured people;
- Hospital net income will fall by about $11 billion over the 2010 through 2019 period reflecting reductions in uncompensated care and new utilization for newly insured people; and

Physician revenues will increase by $130 billion over the 2010 through 2019 period, although these effects will vary widely across providers.

Appendix C:
Master Consulting Agreement

MASTER CONSULTING AGREEMENT

THIS AGREEMENT is made as of December ___, 2010 (the "Agreement Date") by and between **The Lewin Group, Inc.** ("Consultant") at 3130 Fairview Park Drive, Falls Church, Virginia 22042, and ______________________ located at __________________________ ("Client").

Client wishes to obtain consulting services from Consultant. This Agreement sets forth the terms under which Consultant will provide the requested products and services.

1. Services

1.1 Client agrees to retain Consultant to perform the consulting services for Client, on a task-by-task basis (the "Services"), including creation of Deliverables (as defined in Section 3.1), and Consultant agrees to furnish the Services according to the terms and subject to the conditions set forth in this Agreement. During the term of this Agreement, Client and Consultant will execute statements of work defining the Services (each "Statement of Work"). Each Statement of Work shall include any maximum total expenditure authorized, the Deliverables, Consultant's compensation and additional terms and conditions, if any, applicable to a particular engagement. Statements of Work which are executed by the parties shall reference this Agreement and shall become part of this Agreement from the effective date of the Statement of Work. In the event of a conflict between the provisions of this Agreement and the specific provisions set forth in a Statement of Work, the provisions of such Statement of Work shall prevail.

1.2 Unless specifically prohibited in a Statement of Work, Consultant, at its discretion, may exchange or replace personnel performing services under any Statement of Work with other personnel with similar skills and at similar rates.

1.3 Client acknowledges that Consultant provides similar services for a broad range of other clients and agrees that Consultant shall be free to work for other clients in matters that do not involve the use of any Confidential Information that has been disclosed to Consultant by Client under this Agreement.

2. Fees and Payment terms.

2.1 Client shall pay Consultant for the Services on either a time and materials or fixed price basis, in the amounts set forth on each Statement of Work. Client shall pay Consultant for any additional billable services, which Client requests and Consultant performs and which are not specified in any Statement of Work, at Consultant's then-current time and materials rates. Client will reimburse Consultant for all reasonable out of pocket expenses incurred in performing under this Agreement. All invoices will be stated in and all payments made in U.S. dollars. Client shall pay all applicable sales, use, and any other taxes (other than Consultant's income taxes), however designated, which are collected or levied on account of this Agreement.

2.2 Client agrees to pay all fees and expenses invoiced by Consultant within thirty days after the date of each invoice. Undisputed payments not received by the due date shall bear interest at a rate equal to the lesser of one and one-half percent (1½ %) per month, or the maximum rate allowed by law. In the event that payment has not been made in accordance with the terms of this Agreement, in addition to any other remedy Consultant may have under law or equity, Consultant may stop work and/or terminate this Agreement. Client shall reimburse Consultant for all costs, including but not limited to attorney fees, which are incurred by Consultant in attempting to obtain payment under this Agreement which are ninety (90) days or more past due.

3. Ownership of Materials Related to Services.

3.1 As used in this Agreement, "Deliverables" shall mean tangible work product of Services delivered by Consultant to Client pursuant to one or more Statements of Work. Any Deliverables, except as provided in Section 3.3 below and except for any Consultant Tools (as defined below) contained therein, delivered by Consultant to Client (the "Transferred Deliverables') in the course of providing the Services shall be the property of Client from and after the date on which Client pays Consultant the undisputed fees with respect to the applicable Transferred Deliverable. Accordingly, Consultant assigns to Client, effective on that date, any and all of its rights in such Transferred Deliverables together with any and all rights in the nature of copyright and all other intellectual property rights, which it may have in such Transferred Deliverables. Client shall take the necessary actions to ensure that only accurate, complete versions of the Deliverables and analyses developed by Consultant under this Agreement are used by Client and/or disclosed by Client to others. Client shall indemnify Consultant against any liability related to Deliverables that have been changed without Consultant's written approval or have been used for a purpose not expressly authorized by Consultant in writing under this Agreement. In the event that Client uses Consultant's name or attributes any conclusions to Consultant, Consultant reserves the right to itself go public with a correction, clarification, or release of the full text of the Deliverable. Client agrees that when it is the intent of this Agreement to make a Deliverable public, Consultant shall have the right to post information about the Deliverable on its website (www.lewin.com), up to and including posting a final report.

3.2 Consultant may use proprietary tools, computer programs, algorithms, databases, methods and techniques, processes and other materials and ideas developed by itself or others to perform the Services for Client ("Consultant Tools"). Client acknowledges and agrees that the Consultant Tools, including any modifications, improvements, adaptations, or enhancements thereto or new versions thereof, are not deemed a Transferred Deliverable or "work made for hire" under this Agreement and remain the sole property of Consultant.

3.3 Consultant shall not be deemed to have any ownership rights data provided to Consultant by Client pursuant to the terms of this Agreement. However, during and after the term of this Agreement, Consultant may use, transfer and combine data received from Client ("Client Data"), and information derived from that data for preparing normative benchmark data, and for internal research and analytical purposes, but only in a manner that is consistent with applicable law that does not identify Client as a source of the data, and that does not disclose Client-specific experience. Consultant may also perform data aggregation and use de-identified information, so long as such use is consistent with applicable law.

3.4 Deliverables will not be reviewed by Consultant's parent companies, Ingenix or United Health Group ("Parent"), prior to their release to Client. Consultant will notify Client in advance if Consultant seeks to use peer reviewers or other experts from Consultant's Parent to assist in the development of the Deliverables. Consultant and its Parent reserve the right to review and comment on the Client's press release concerning this project prior to its release. Client shall provide Consultant and its Parent two business days to review and reply with comment to Client on any press release or other publicity or marketing announcements prior to Client's release of the same.

4. Warranties.

4.1 Consultant warrants that each of Consultant's employees, agents and subcontractors assigned to perform any Services shall have the proper skill, training, and experience to perform the Services, and the Services will be performed in a competent and professional manner. Unless otherwise agreed in a Statement of Work, Consultant agrees to re-perform any Services not in compliance with this warranty that are brought to its attention in writing within thirty (30) days after those Services are

delivered to Client. Additionally, Consultant warrants that its Deliverables shall conform in all material respects to their relevant specifications for a period of thirty (30) days after delivery to Client. Consultant agrees to correct any such Deliverables not in compliance with this warranty brought to its attention in writing within thirty (30) days after delivery to Client of such Deliverable.

4.2 Except as expressly provided in this Agreement, CONSULTANT MAKES NO WARRANTIES OR REPRESENTATIONS RELATING TO THE SERVICES OR DELIVERABLES, EXPRESS OR IMPLIED, AND SPECIFICALLY DISCLAIMS THE WARRANTIES OF MERCHANTABILITY AND FITNESS FOR A PARTICULAR PURPOSE.

5. Term and Termination

5.1 This Agreement commences as of the Agreement Date. Unless earlier terminated as provided in this Agreement, this Agreement continues until the earlier of two (2) years after the Agreement Date or (b) the expiration of all Statements of Work to this Agreement. Section 3.3 and all Sections of this Agreement (including the Statements of Work) relating to confidentiality, ownership of intellectual property, indemnification, or limitations of liability shall survive termination or expiration of this Agreement.

5.2 Client may terminate this Agreement at its convenience, with or without cause upon thirty (30) days prior written notice to Consultant. Consultant may terminate this Agreement for convenience, with or without cause, upon thirty (30) days written notice to Client, provided that termination by Consultant pursuant to this Section 6.2 shall not be effective until completion of any specifically defined Services in a then-current Statement of Work, unless otherwise agreed by the parties in writing. Upon any such termination, Consultant will be paid all fees and expenses which have been incurred or earned in connection with the performance of the Services through the effective date of such termination.

5.3 In addition, either party may terminate this Agreement or any outstanding Statement of Work, after written notice to the other party, in the event that the other party breaches a material term of this Agreement or any Statement of Work and such breach remains unresolved at the end of thirty (30) days after receipt of such notice. Upon any such termination, Consultant will be paid all fees and expenses which have been incurred or earned in connection with the performance of the Services through the effective date of such termination.

5.4 Except as set out in Section 5.5 below, any dispute between the parties regarding this Agreement that is not cured or otherwise resolved through the processes described in Sections 5.3 shall be resolved through arbitration conducted in accordance with the Commercial Dispute Resolutions Rules of the American Arbitration Association then in effect. The arbitration proceeding will be conducted in the English language. The arbitrator(s) may grant any remedy or relief deemed just and equitable with the exception of punitive or exemplary damages. The arbitrator(s) shall have no power to vary or ignore the terms of this Agreement and shall be bound by controlling law. The decision of the arbitrator, or a majority of the arbitration panel, shall be final and binding upon the parties with no right to appeal. Judgment may be entered upon the award of the arbitrator(s) in any court of competent jurisdiction. Each party shall assume its own costs, and the compensation and expenses of the arbitrator(s) and any administrative fees or costs associated with the arbitration proceeding shall be borne equally by each party. The parties shall proceed diligently with the performance of this Agreement pending the resolution of any dispute.

5.5 Notwithstanding Sections 5.3 or 5.4 above (collectively, "the Dispute Resolution Processes"), in the event that a party breaches this Agreement, the non-breaching party may apply to a court of competent jurisdiction for emergency injunctive relief during or prior to the invocation of the

Dispute Resolution Processes. Once the court has ruled on the non-breaching party's initial application for emergency injunctive relief, however, the non-breaching Party may not seek additional relief from the court and must resolve any additional issues through the Dispute Resolution Processes.

6. Limitation of Remedies and Indemnification

6.1 This Section 6.1 limits the parties' liability to each other in actions between the parties brought under this Agreement. This Section 6.1 does not limit (a) the parties' obligations to each other under Sections 6.2 or 6.3 of this Agreement, or (b) the liability either party may have to the other party for breach of Section 7 of this Agreement, or (c) Client's liability to Consultant for failure to pay amounts due under this Agreement or any Schedule. Each party's liability to the other party for direct damages arising out of this Agreement shall not exceed the amount Client has paid or owes Consultant under this Agreement for the 12-month period immediately prior to the incident giving rise to the cause of action. Neither party shall be responsible under this Agreement for any indirect, incidental, special or consequential damages resulting from either party's performance or failure to perform under this Agreement, including, without limitation, the use of or inability to use the Services, any damage to equipment and any cost of recovering lost data or of reprogramming.

6.2 When a third party sues Client or a governmental agency assesses a fine or penalty against Client, Consultant agrees to defend Client against and hold it harmless from all third-party claims, damages and liabilities resulting from (a) a claim that the Services or Deliverables infringe a United States patent or United States copyright, (b) Consultant's breach of this Agreement; provided that Client gives Consultant prompt, written notice of any such claim, sole control of the defense and settlement of such claim, and all reasonable assistance to defend such claim. Client shall not agree to settle the claim without Consultant's written consent, provided that such consent is not unreasonably withheld, conditioned or delayed. Consultant shall have no obligations under this Section if such claims, damages and liabilities result from Client's breach of this Agreement or Client's unauthorized or inappropriate use of or modifications to the Deliverables. This indemnification provision shall not be deemed to waive or limit any other rights.

6.3 When a third party sues Consultant or a governmental agency assesses a fine or penalty against Consultant, Client agrees to defend Consultant against and hold Consultant harmless from all third-party claims, damages and liabilities resulting from (a) use of Client Data by any third party to whom Client has directed Consultant to deliver such data; or (b) or Client's business decisions made after use of the Services or the Deliverables; or (c) Client's breach of this Agreement; provided that Consultant gives Client prompt, written notice of any such claim, and all reasonable assistance to defend such claim. Consultant shall not agree to settle the claim without Client's written consent, provided that such consent is not unreasonably withheld, conditioned or delayed. Client shall have no obligation under this Section 7.3 if such claims, damages and liabilities result from Consultant's breach of this Agreement. This indemnification provision shall not be deemed to waive or limit any other rights.

7. Confidential information.

7.1 Each party acknowledges that in the course of performing under this Agreement, or in the course of discussing or negotiating Schedules or future agreements between the parties, each party may learn confidential, trade secret, or proprietary information concerning the other party or third parties to whom the other party has an obligation of confidentiality ("Confidential Information"). Without limiting the foregoing, Consultant's Confidential Information shall include, without limitation, the terms of this Agreement, financial information and employee information; information regarding Consultant products, marketing plans, business plans, Client names and lists, Services; reports generated by or for Consultant; Consultant's methods of database creation; Consultant's translation, standardization, enhancement, and health data analysis techniques, health data reporting and profiling methods and

formats; software tools for report creation, distribution and retrieval; and associated algorithms, developments, improvements, know-how, code (object and source), programs, software architecture, technology and trade secrets. Without limiting the foregoing, Client's Confidential Information shall include information regarding Client's business and information regarding Client's patients, premiums and claims data.

7.2 Each party agrees that (a) it will use the other party's Confidential Information only as may be necessary in the course of performing duties, receiving services or exercising rights under this Agreement; (b) it will treat such information as confidential and proprietary; (c) it will not disclose such information orally or in writing to any third party without the prior written consent of the other party; (d) it will take all reasonable precautions to protect the other party's Confidential Information; and (e) it will not otherwise appropriate such information to its own use or to the use of any other person or entity. Without limiting the foregoing, each party agrees to take at least such precautions to protect the other party's Confidential Information as it takes to protect its own Confidential Information. Each party is solely responsible for all use of the other party's Confidential Information by anyone who gains access to the Confidential Information under such party's authorization. Upon termination or expiration (without renewal) of this Agreement, each party will return to the other party or certify as destroyed all tangible items containing any of the other party's Confidential Information that are held by that party or its employees, agents or contractors, other than archival copies. Each party agrees to notify the other party if it becomes aware of any unauthorized use or disclosure of the other party's Confidential Information.

7.3 If either party believes it is required by law or by a subpoena or court order to disclose any of the other party's Confidential Information, it shall promptly notify the other party and shall make all reasonable efforts to allow the other party an opportunity to seek a protective order or other judicial relief prior to any disclosure.

7.4 Nothing in this Agreement shall be construed to restrict disclosure or use of information that (a) was in the possession of or rightfully known by the recipient, without an obligation to maintain its confidentiality, prior to receipt from the other party; (b) is or becomes generally known to the public without violation of this Agreement; (c) is obtained by the recipient in good faith from a third party having the right to disclose it without an obligation of confidentiality; or (d) is independently developed by the receiving party without reference to the other party's Confidential Information.

8. General

8.1 This Agreement, including any Statements of Work, constitutes the entire understanding between the parties and supersedes all prior proposals, communications and agreements between the parties relating to its subject matter. No amendment, change, or waiver of any provision of this Agreement will be binding unless in writing and signed by both parties. In the event one or more of the provisions of this Agreement are found to be invalid, illegal or unenforceable by a court with jurisdiction, the remaining provisions shall continue in full force and effect. Consultant may use subcontractors to perform under this Agreement, but Consultant shall remain responsible for its obligations under this Agreement.

8.2 Neither Party shall assign or transfer this Agreement or any of its obligations hereunder without the other party's express, prior written consent. Notwithstanding the forgoing, either party may assign the agreement in connection with any merger, consolidation or sale of all or substantially all of its assets.

8.3 In the event that any term or provision of this Agreement shall be held to be invalid, void or unenforceable, then the remainder of this Agreement shall not be affected, impaired or invalidated,

and each such term and provision of this Agreement shall be valid and enforceable to the fullest extent permitted by law.

8.4 All notices, requests and other communications hereunder shall be in writing. Communications to the Consultant shall be addressed as follows:

For Consultant:
The Lewin Group, Inc.
Attn: Contracts Department
3130 Fairview Park Drive
Falls Church, VA 22042

With copy to:
Ingenix, Inc.
Attn: General Counsel
12125 Technology Drive
Eden Prairie, MN 55344 USA

For Client:

With a Copy to :

8.5 Neither Client nor Consultant will disclose the financial terms of this Agreement to any other party, except to a party's accountants, attorneys, consultants and agents, or as agreed by the parties or as compelled by court order.

8.6 Consultant's relationship to Client is that of an independent contractor. Neither party shall be deemed to be or hold itself out as a partner, agent, employee or joint venture partner of the other party.

8.7 The obligations of the parties under this Agreement shall be suspended, to the extent a party is hindered or prevented from complying therewith because of labor disturbances (including strikes or lockouts), acts of war, acts of terrorism, vandalism or other aggression, acts of God, fires, storms, accidents, governmental regulations, failure of Internet access or service, or any other cause whatsoever beyond a party's control. In addition, Consultant's failure to perform under this Agreement shall be excused, and shall not be cause for termination, if such failure to perform is due to Client undertaking actions or failing to undertake actions so that Consultant is or would be prohibited from the due performance of any material covenant, condition or agreement contained in this Agreement.

8.8 This Agreement, including any and all Statements of Work thereto, may be executed in counterparts, each of which shall be deemed an original and all of which together shall be considered one and the same agreement.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by their duly authorized representatives as of the Effective Date.

CLIENT

By:________________________________

Name:______________________________

THE LEWIN GROUP, INC.

By:________________________________

Name:______________________________

Title:____________________________________

Title:____________________________________