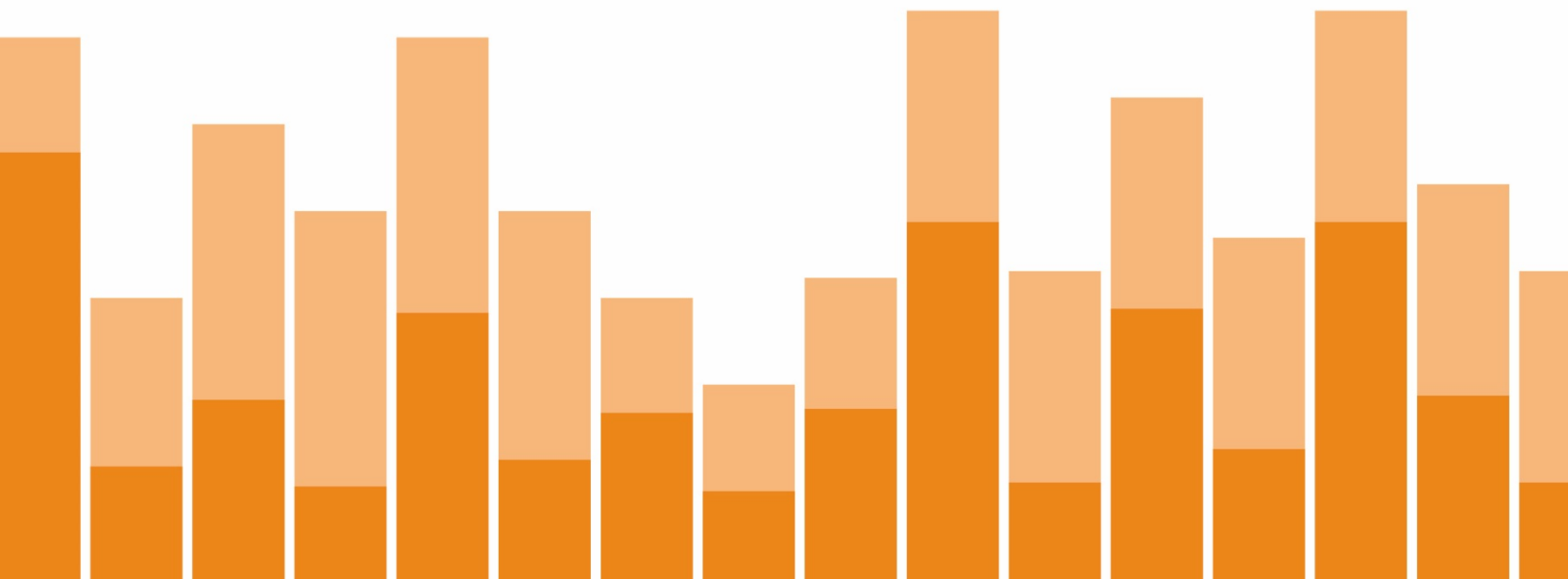


How the Government as a Payer Shapes the Health Care Marketplace

By Tevi D. Troy



American Health Policy Institute (AHPI) is a non-partisan 501(c)(3) think tank, established to examine the impact of health policy on large employers, and to explore and propose policies that will help bolster the ability of large employers to provide quality, affordable health care to employees and their dependents. The Affordable Care Act has catalyzed a national debate about the future of health care in the United States, and the Institute serves to provide thought leadership grounded in the practical experience of America's largest employers. To learn more, visit americanhealthpolicy.org.

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Executive Summary

The federal government is the largest *single* payer of health care in the United States¹, accounting for more than a quarter of all U.S. spending on health care. Having a single entity provide so much of the revenue for an industry gives that entity outsized influence in that industry. Consequently, as the nation's largest payer, the federal government is able to significantly shape and move the health care market. Whether it is the Centers for Medicare and Medicaid Services (CMS) determining which treatments and technologies are worth covering and how much they are willing to reimburse for them; the Agency for Healthcare Research and Quality (AHRQ) mandating quality and safety standards; or the new Affordable Care Act (ACA) exchanges setting the standard for benefit packages throughout the health insurance market, it is clear that government agencies and their mandates play a powerful role in guiding the provision of health benefits and the overall construct of the market.

In recent years, a number of health policy trends have highlighted the significant role the federal government plays as a payer of health care:

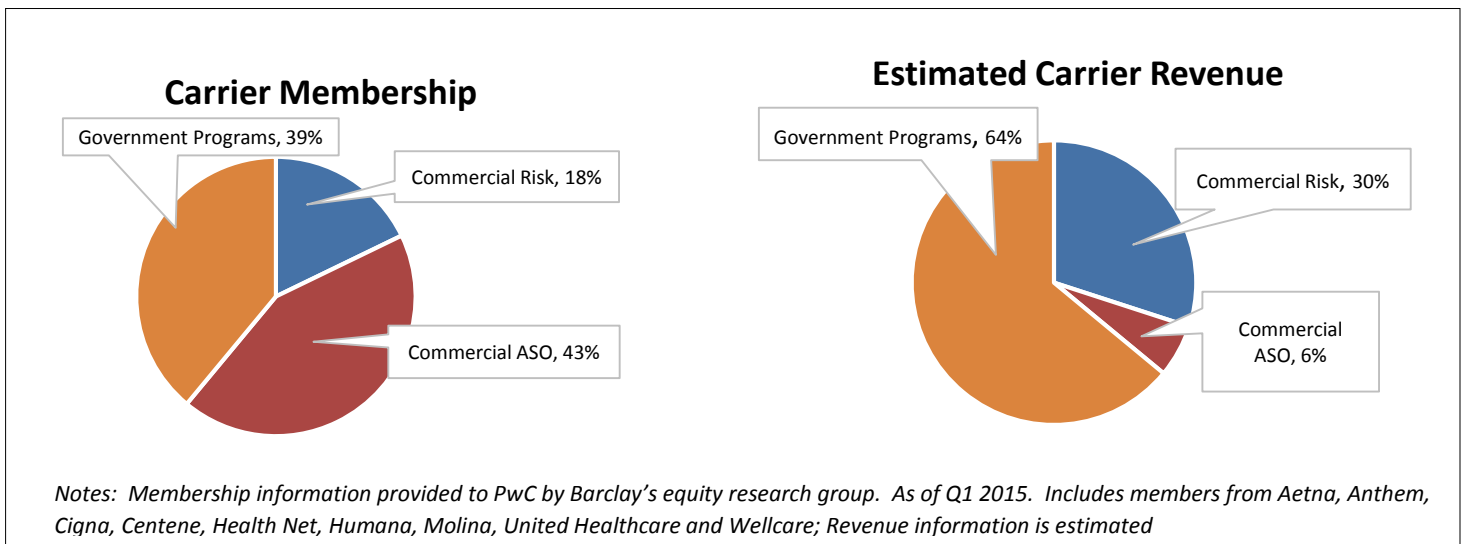
- The federal government's role as both regulator and payer of the insurance industry has resulted in several key insurance mergers over the past year, which has reshaped the country's health insurance market;
- The government encourages businesses to serve as test cases for government preferred payment models such as bundled payments and ACOs;
- The federal government's role as the dominant health care payer has a variety of powerful effects on reimbursement to providers—most notably through Medicare, but also in terms of the potential cost shifting that occurs and is borne by private payers;
- The federal government's ACA exchange plans serve as a benchmark for private plans, which has a ripple effect in setting prices for other insurance plans, as well as for employers determining levels of coverage;
- The Federal Employee Health Benefit Plan (FEHBP), influences not only the shape of health plans provided, but also who is providing them;
- The government's dominant payer role shapes the face of innovation adoption. For example, when it comes to telehealth, Medicare reimbursement models are determining how new technology will be integrated in the practice of medicine; and
- The government's Agency for Healthcare Research and Quality (AHRQ) sets national health care quality standards, which play a role in payment models.

As this paper shows, these various ways in which the U.S. government in its role as payer attempts to influence U.S. health care beg the question of what other players in the space will do in response—and what this could possibly mean for the nation's health care system in the future. These other players in the marketplace will likely reconsider their respective roles and strategies to see if they, too, have the ability to consolidate and use collective influence. Health care providers, insurance carriers, and pharmacy benefit managers are already doing so, and other entities, such as employers, may follow as well. In the process, these consolidating entities may change the face of health care as we know it. The key question is whether the changes undertaken by these players will, together with government, enhance or detract from the widely proclaimed goal of better quality of health care at a more affordable cost.

Shaping Business Models

One of the major ways in which the federal government's payment role shapes our health care industry is in its impact on large insurers. This influence takes place in a number of ways that go beyond the federal government's role as a regulator. It is the government's role as a revenue source that makes it so important to the insurance industry. According to an estimate done by Barclay's Equity Research Group, while employers account for 43 percent of the major carrier's covered lives and government sponsored programs account for a roughly equivalent 39 percent of the carriers covered lives, the government accounts for 64 percent of the major carrier's revenue compared to just 6 percent coming from employers (See chart below).²

Sources of Insurance Carrier Revenue and Covered Lives



The disproportionate amount of revenue coming from government (10 times more than employers) means that the carriers are cognizant that the government is their main customer when designing business models. Moreover, carrier revenue growth has been largely driven by government programs over the past three years. One of the reasons for the recent merger mania among carriers is an effort to accommodate this large and growing customer. According to an analysis by *U.S. News and World Report*, the mergers were initially triggered by the onset of Medicare managed care plans decades ago, but picked up steam recently with the ACA and its effort to move increasing numbers of Americans into government-sponsored coverage, be it through the ACA exchanges or Medicaid.³ Compounding this shift is the movement of the growing number of retirees entering into Medicare Advantage programs. These shifts are part of a larger movement away from private sector and towards public sector coverage.

Insurance industry commentator Wendell Potter wrote that we are moving towards a system of “more and more people enrolled in public programs, which are going to grow as baby boomers age and the Medicaid program grows.”⁴ As the carriers see this shift towards more enrollees in public programs, they adjust their business models to accommodate those customers. The best way to deal with a big customer such as the federal government is to develop some heft of one’s own, hence this movement towards mergers among the large carriers. As University of California’s Berkeley Center for Health Technology’s James C. Robinson observed, the result of this “huge and inexorable” shift will be a government that is “paying for more and more care provided by fewer and fewer companies.”⁵

Of course, it is not just the business models of the carriers that is impacted by the development of government as the dominant payer in the marketplace, but the overall health system as well. One study of consolidation by the American Medical Association—admittedly an interested party—found that insurance industry mergers currently under consideration would have the effect of reducing competition in 154 metropolitan areas in 23 states. The study also found that seven of the ten metropolitan areas studied already lacked significant competition among insurers; that one insurer dominated the market in two of the five areas studied; and that 14 states had one insurer dominating the market.⁶ The probable result of these rational strategies undertaken by carriers is diminished competition in the marketplace and fewer choices for consumers.

Another way that government influences business models is by encouraging businesses to serve as test cases, or guinea pigs for government preferred payment models such as bundled payments and accountable care organizations. While bundled payments may be mandated at some point, they currently remain at the demonstration program phase. The bundled payment method effectively shifts some of the insurance risk from the government to health care providers and creates an incentive for providers to better manage patient care. A recent Avalere study found, “9 percent of U.S. acute care hospitals and 7 percent of skilled nursing facilities are voluntarily assuming financial risk by participating in the latest phase of the Centers for Medicare & Medicaid Services’ Bundled Payments for Care Improvement Initiative.”⁷ The demonstration program may or may not work out for these providers, but it is a safe bet that many of them opted to participate in the program because CMS, as the largest single payer, was signaling its interest in their making the change.⁸

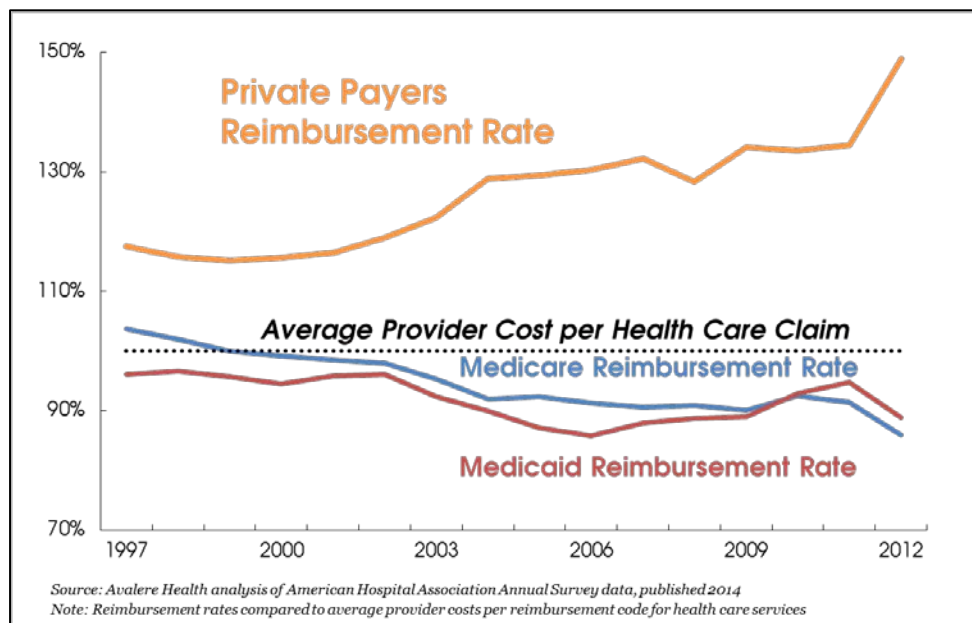
The federal government’s role as the dominant health care payer also has a variety of powerful effects on reimbursements to health care providers. These influences manifest in both the public and the private sector. Within the public sector, the problem of “dual eligibles”—approximately 9 million Medicare beneficiaries under 65 who are also eligible for Medicaid as well—has been known to present funding challenges to both programs, not to mention coordination of care problems for the beneficiaries themselves.⁹ These problems arise because of the incentives to engage in “cost shifting” between the two programs. A nursing home dealing with a costly patient who is reimbursed via Medicaid might seek to transfer such a patient to a hospital, which is reimbursed by Medicare. The hospital, for the very same reasons, might seek to transfer its own costly patients to a nursing home. This hypothetical example is only one of a multitude of ways that health care providers cost shift within the two programs.

States also engage in this behavior, as they have been found to encourage transferring patients from Medicaid-reimbursed care—the costs of which are split with the federal government—to Medicare-reimbursed care, for which the federal government pays without a state split.¹⁰ Compounding matters is the fact that dual eligible patients tend to be both poorer and sicker than average, increasing costs for both the health care providers and the government programs themselves. In this way, the dual eligible uncertainty, created by having government as such a large payer, can wreak havoc on patients who fail to receive the coordinated care they need, and create administrative nightmares for providers.

In a related way, the government as dominant payer has a large effect on physician payments under Medicare. Physician payments have been a huge political issue. Nowhere was the impact of government's dominant role as a payer seen more than in the so called “doc fix”—through which the government adjusted legislatively mandated cuts in physician reimbursement rates, cuts that Congress would then undo each year before they went into effect. The “doc fix” proved to be a perennial problem until Congress recently came up with a permanent fix to the situation. But beyond the political problem of the Sustainable Growth Rate, or SGR, there is also the issue of the impact Medicare payments to physicians have had on private sector reimbursements. According to a 2015 study by the National Bureau of Economic Research (NBER), shifts in Medicare payment rates have had an outsized influence on private sector physician reimbursements.¹¹ The study found that every one dollar increase in Medicare fees corresponded to a \$1.16 increase in private sector prices.¹² What this increase means is that Medicare pricing decisions have a doubly powerful impact: not only do they increase costs for Medicare patients, but they also have an amplifying effect on private sector prices.

Government reimbursement levels have an impact on private sector spending in an additional way. Because reimbursements from government programs like Medicare and Medicaid are lower than the average cost of serving those patients, providers charge privately insured patients higher rates in order to recoup their costs. This increase in private sector prices to adjust for government payment levels is called “cost-shifting,” and it is a controversial concept. Some researchers deny or minimize its existence, while other analysts insist it is a real phenomenon. Regardless of where the academic literature stands, one thing is clear: reimbursements from government programs are and have been lower than the average cost of patient care, as the chart below shows. Furthermore, the chart also shows that the gap between private and public reimbursement rates is widening in the wake of the ACA. Given these facts and the fact that executives who run provider systems are aware of these realities, they may very well plan their pricing systems accordingly. While the extent to which cost shifting takes place may be a matter for debate, the fact that reimbursement differentials affect provider thinking, their overall approach to pricing, and their business models, is not in doubt.

Providers Shifting Medicare/Medicaid Costs to Private Payers



A related issue to the government reimbursement rates comes in the form of access to doctors. If doctors know that they will be paid less as a result of treating Medicaid patients, they might not prioritize said patients. It goes without saying that physicians should and generally do treat patients under their care equally, but the issue here is which patients will be under their care. There have been a number of studies that looked at the question of whether government reimbursement policies affected the ability of patients to get the doctors they want. One 2008 *Health Affairs* study found that, while rates were important in physician participation decisions, the speed of reimbursement was a key factor as well.¹³ According to the study, “slower Medicaid reimbursement times were associated with lower physician participation in Medicaid.”¹⁴ A more recent study by the Advisory Board Company found significant variations in doctors’ accepting new Medicaid patients by state.¹⁵ Overall, only 69 percent of doctors nationwide were accepting new Medicaid patients, suggesting that doctors take Medicaid status into account when deciding whether to accept new patients. Rejection rates for new Medicare and privately insured patients were about half the level of those with Medicaid, in the 15 to 16 percent range.¹⁶ And as reimbursement levels vary by state, some states were lower than that. New Jersey, for example, was the worst state in this regard, as only 38.7 percent of doctors were accepting new Medicaid patients. Florida, California, New York, and Louisiana made up the rest of the bottom five.¹⁷ Collectively, the populations in those five states constitute 30 percent of the entire U.S. population.

Insurance Premiums

In addition to the influence that government health care payments exert on provider and insurance carrier business models, they are also a significant influence on carrier pricing. Since the advent of the ACA, the government has been subsidizing insurance policies purchased via the ACA exchanges. The exchanges are set up so that policies are grouped in bands—platinum, gold, silver, and bronze—according to the value of the plan offered on the exchange. As a result of this system, and the government’s role in subsidizing the plans, the second lowest cost “silver” plans have emerged as what *The Wall Street Journal* has called “a key metric for premiums around the country.”¹⁸ What this means is that other, non-federally subsidized plans look to the silver plans as models for premium and coverage levels, as do employers in establishing levels of coverage for employer-sponsored health plans.

In an October 2015 analysis, the *Washington Post*’s Amy Goldstein found spikes in premiums for silver plans, which she called “a level of coverage that serves as the benchmark for federal subsidies that help most consumers buying coverage under the Affordable Care Act.” According to Goldstein, the premiums for the plans were rising an average of 7.5 percent, four times higher than the previous year’s increases.¹⁹ Given the silver plans’ status as a benchmark for other plans, these increases have a ripple effect in setting prices for other insurance plans, as well as for employers determining levels of coverage.

According to the Department of Health and Human Services, 7.8 million people, about two thirds of all exchange enrollees, have silver plans, which in part accounts for their outsize impact.²⁰ Another government funded health plan with an outsize impact is the Federal Employee Health Benefit Plan (FEHBP). In this plan, the government is serving in its role as employer, rather than subsidizer of ACA exchange plans, but the impact nonetheless remains significant. FEHBP covers 8 million people, and the government as employer pays 70 percent of the costs of coverage (roughly equivalent to an ACA silver plan), constituting one more important way in which the government as payer helps shape coverage.

With respect to the FEHBP, the government’s dominant payer role influences not only the type of plans that are provided, but also who is providing them. And in doing so, FEHBP shapes the market shares of carriers relative to how those carriers perform in different regions across the country. For example, according to a recent internal paper by the Office of Personnel Management (OPM), which administers the FEHBP, Blue Cross Blue Shield (BCBS) has a higher market share in FEHBP than it does in the rest of the health care marketplace.²¹ Consequently, companies like Aetna, Humana, and UnitedHealthcare Group have lower market shares in FEHBP than in the rest of the market. According to the OPM, BCBS has a higher market share in FEHBP than in 46 of 51 markets.²² By contrast, Aetna has a lower market share in FEHBP than outside of FEHBP in 29 of 32 markets; Humana in 20 of 21 states; and UnitedHealthcare Group in all 45 states in which it operates.²³ This is not to suggest that anything unfair or untoward is going on, only that because of the government’s payer dominance, the FEHBP market, which is more than a \$40 billion market, generates different results than are seen in the non-FEHBP marketplace.²⁴

The journal *Health Affairs* also looked at the question of competition within the FEHBP marketplace and found that “summary measures of concentration in the federal benefits program showed that the market was not competitive.”²⁵ According to the study, most enrollees were in only a few concentrated plans and that one company—BCBS—was a dominant player within that small concentration of players. The study also noted that because the FEHBP was “the largest employer-sponsored plan in the country,” anticompetitive concentration in the FEHBP was likely to occur in the ACA exchanges—modeled initially on the FEHBP approach—as well.²⁶ As the ACA exchanges expand, it is likely that we will see additional market distortions emerge in the form of disproportionate carrier share along the lines of what we are already seeing with disproportionate convergence into one kind of benefit package—the silver plans.

Availability of Innovative Products

Having one single dominant payer in the marketplace shapes the face of innovation as well. One way this comes up is with respect to new ways of practicing medicine. Telehealth, for example, is on the rise due to improvements in technology that will let doctors see patients on screen from a remote location. According to the National Business Group on Health (NBGH), 74 percent of large U.S. employers say they plan to offer telehealth services where permitted under the law, an increase from 48 percent in an earlier survey.²⁷ This suggests that telehealth usage is going to rise rapidly.

When it comes to telehealth adoption, though, Medicare reimbursement models are determining how the new technology will be integrated into the practice of medicine. According to a Department of Health and Human Services (HHS) guidance document, “not all telehealth costs are reimbursed.”²⁸ As the HHS document explains (with less than full clarity):

Medicare, which has to some extent set the standard, reimburses for telehealth services when the originating site (where the patient is) is in a Health Professional Shortage Area (HPSA) or in a county that is outside of any Metropolitan Statistical Area (MSA), defined by HRSA and the Census Bureau, respectively. This originating site must be a medical facility and not the patient's home. Medical facilities include practitioners' offices, hospital, and rural health clinics. This reimbursement is not affected by the location from which the telehealth services are being delivered (the ‘distant’ site). Medicare will only pay for ‘face-to-face’, interactive video consultation services wherein the patient is present. That is, Medicare will cover telemedicine services that mimic normal face-to-face interactions between patients and their health care providers. Medicare does cover store-and-forward applications, such as teleradiology and remote EKG applications, as they do not typically involve direct interactions with patients. Medicare does cover store-and-forward applications, such as teledermatology, in Alaska and Hawaii.²⁹

Assuming your doctor can understand the “bureaucratese,” he or she is welcome to use telehealth as an option, as permitted by their most important payer. But as the guidance shows, teleradiology is more likely to be covered than teledermatology, which is covered in more limited areas. These differentials in coverage mean that certain specialties will be covered more broadly, and will therefore be developed more quickly, than others. In any event, the key point is that Medicare “has to some extent set the standard” for telemedicine. As usual, the largest payer shapes the way in which new technology is applied.³⁰

The largest payer syndrome affects development in the life sciences as well. According to an analysis by the Robert Wood Johnson Foundation's *Changes in Health Care Financing and Organization*, "Medicare's decisions about the coverage of new technology have the potential to impact patterns of care across the country."³¹ As the largest single payer, the federal government helps determine which drugs will be covered, and at what level they will be reimbursed. CMS makes National Coverage Determinations, or NCDs, to determine which products get covered. Private insurance companies then tend to follow CMS' lead in making their own coverage decisions. This means that the NCDs have an outsize influence on whether a new product gets covered in both the public and private sector programs, meaning that a single payer, such as the federal government, can make or break a new product.

Beyond the binary decision of whether or not to cover a product, there is also the question of the reimbursement level at which the product will be covered. A decision that will have a large impact on the product's success, and on its available supply. For example, a 2011 analysis in the *New England Journal of Medicine* found that Medicare reimbursement policies contributed to a shortage in generic chemotherapy drugs,³² and a 2011 Heritage study that looked at 178 drug shortages argued that Medicare reimbursement policies "for outpatient drugs covered under Part B is one of the major reasons for shortages."³³ Whether via coverage itself, or the payment levels for coverage, it is clear that CMS, as the major payer in the health care market, can determine health care products' success, and control availability of products in the process.

Quality Measures

In some areas, it might seem that having one dominant payer could be advantageous in bringing clarity to the marketplace. An example of this would be using the existence of a large payer to improved evaluations of our health system, particularly through improved quality measures. Quality measures can help distinguish good care from bad care and can help employers find superior health care value. The good news is that many health care experts agree about this need. The bad news, unfortunately, is that so many health care experts recognize this need that, according to the Institute of Medicine (IOM), we are inundated with too many quality measures.³⁴ Even worse, according to the IOM, the measures themselves lack focus and consistency.³⁵

There are four major groups, for example, that measure quality, and those groups' assessments often disagree with one another. Across these four groups, no hospital managed to secure top marks: only 10 percent of highly rated hospitals in at least one measurement managed to be highly rated by another one of the services; and 27 top rated hospitals ended up on the bottom in at least one other ranking.³⁶

The situation is so absurd that it calls for establishing one overarching system to bring order to the chaos. Unfortunately, getting the largest single payer—the federal government—involved only compounds the confusion. According to Dartmouth's Scott Wallace, the federal government measures process more than quality: 102 of 123 metrics at the government's Hospital Compare site look at process, not quality.³⁷ Furthermore, as the largest payer the federal government must be listened to, but it is not improving matters. CMS often burdens hospitals with additional requests for metrics, which adds to the hospitals' administrative burdens without necessarily helping on the quality front.³⁸

The Agency for Healthcare Research and Quality (AHRQ), the U.S. government agency responsible for quality standards, has an alphabet soup of four different quality indicators that it uses: HQIs, PSIs, PQIs, and PDIs. One measures hospital care, another measures adverse events; a third looks at hospital admissions; and the fourth combines the first three in the pediatric context. AHRQ uses all of these measures while being fully aware that there are many other entities that already look at quality. As an AHRQ paper notes, “many other organizations, both public and private, have developed and used their own sets of quality indicators.”³⁹ Despite the overlap and redundancies, the AHRQ measures come from the dominant payers, so they must be adhered to, along with whatever other ones hospitals are obliged to or choose to employ.⁴⁰

If we could unify and consolidate these measurements, however, that could potentially lead to real and significant savings in health care spending. Such savings have the potential to moderate health care spending growth over time, which would compound the savings, for taxpayers and employers alike, by changing the trend lines showing the annual increases in health care spending. Unfortunately, the federal government, as dominant payer, has only compounded the confusion over quality.

Conclusion

This study does not presume to present anything close to an exhaustive listing of the myriad ways that government as payer impacts—some would say skews—the health care marketplace.

But even a non-exhaustive review reveals that having one enormous payer can have outside influence on players across the health care support chain. This review also suggests that other payers could use their own collective leverage to drive better results for their customers as well. It is unlikely that any one payer could have as much influence as the federal government. In addition to size and dollars, the government also maintains the ability to regulate, putting the force of law behind its decisions and preferences. But even without the same size, and even without the regulatory apparatus, other entities could potentially use their own outside spending patterns to drive prices and overall change in ways favorable to those entities.

Employers, for example, have limited influence on the health care marketplace when navigating the system as individual entities. Yet, they collectively cover far more lives than the government. More than half of all Americans—175 million—receive their health insurance from an employer. In providing coverage for about 54 percent of covered Americans, employers spend over a fifth of all U.S. health expenditures. Despite this enormous spending, individual employers lack the power to guide the market to the extent that the government does. If employers could leverage even a fraction of the power that the government exercises as payer, they would have a transformative impact on the provision of health care in the U.S., potentially guiding the marketplace in a way that generates true competition within the supply chain, drives quality improvement and affordability in health care, and accelerates innovation.

Employers, of course, are not the only ones to realize this point. In recent years, carriers, pharmacy benefit managers (PBMs), and hospitals have consolidated, recognizing that collective size brings marketplace benefits. Expect more health care players to follow this path in the years ahead.

¹ The federal government, acting as a *single* payer, accounts for 25.9 percent of national health expenditures (NHE). Although households account for 28.2 percent of NHE, this spending arises from millions of diffuse sources. Employers collectively account for 20.9 percent of NHE, state governments collectively for 17.4 percent, and private charities for 7.5 percent.

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²⁰ Because the ACA premium subsidy is tied to the second lowest cost silver plan available to the enrollee, most people choose silver plans in the ACA exchanges. Only 7 percent chose a gold plan, and only 3 percent chose a platinum plan. "Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report." ASPE Issue Brief, March 10, 2015. http://aspe.hhs.gov/sites/default/files/pdf/83656/ib_2015mar_enrollment.pdf

²¹ Health Plan Competition in the FEHB Program, Unsigned OPM Paper. *Washington Post*, August 6, 2012. <https://www.washingtonpost.com/r/2010-2019/WashingtonPost/2012/08/06/National-Politics/Graphics/FEHBOPMcompplan.pdf>

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²³ *Id.*

²⁴ *Id.*

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