THIRD WAY

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Local Examples: Innovations in Decision Support and Default Choice

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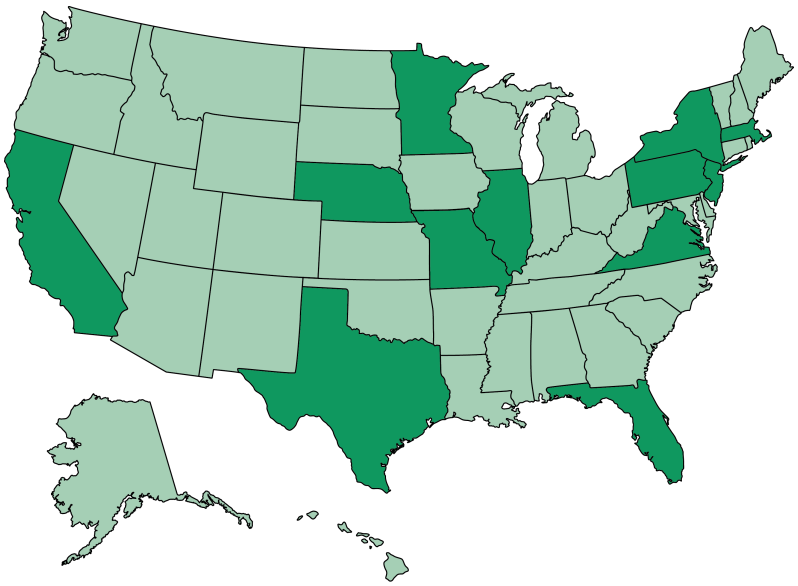
When Medicare beneficiaries have trouble shopping for a health plan, they can end up spending more and getting worse care. Choosing a Medicare plan is difficult because beneficiaries do not have access to information about the quality of care in original Medicare for their area. Also, any complex choice involves several challenges, including being overwhelmed by too much information and too many choices, getting stuck in making a new choice, and favoring a current plan over another that may be better.



Finding the right Medicare plan doesn't need to be this hard. By providing Medicare beneficiaries with decision support tools and safer default choices, seniors can find the right plan for them, leading to less spending by both seniors and government and better health outcomes for beneficiaries.

Health care consumers across the country are already using decision support tools and default choices to shop for and enroll in health insurance plans that better reflect their preferences. Below are just a few examples:

Nationwide

eHealth

An online service, eHealth, has assembled much of the critical information to assist Medicare beneficiaries in comparing coverage choices on its website, eHealthMedicare.com. Here, beneficiaries may compare up to three Medicare Advantage, Medigap, or Medicare Part D prescription drug plans to original Medicare. (Beneficiaries must shop separately for Medicare Advantage, Medigap, and Part D plans.) To help beneficiaries choose a plan, the site compares the plans' premium cost, star rating, deductibles, copayments or coinsurance for various services, and much more. To provide further assistance, eHealthMedicare.com provides the opportunity to speak with a licensed insurance agent who will help beneficiaries determine which type of coverage is best

(for example, Medicare + Medigap + Part D or Medicare Advantage?) and select and enroll in the right plan for them. Agents are available 12 hours per day and beneficiaries may make an appointment online for a convenient time.

HealthCare.com

HealthCare.com assists consumers with shopping for and enrolling in health insurance. After entering one's age, gender, zip code, tobacco use, and estimated household income and size (for purposes of subsidy estimation), the site provides information about available plans both on and off the consumer's state Marketplace. Subsidy-eligible consumers are directed to the appropriate Marketplace to ensure they receive premium assistance, and information on Medicaid is available to those who may be eligible, based on household size and income. The site allows for comparison of high-level plan details (premium, deductible, out-of-pocket maximum, etc.) for several plans as selected by the user. For more personal decision support services, licensed agents are available via phone. HealthCare.com advertises Medicare plans, but users seeking these plans are redirected to eHealthMedicare.com.

Picwell

Picwell, a new company with leadership from professors and graduates at the Wharton School at the University of Pennsylvania, provides a decision support tool to help consumers easily and confidently choose the right plan for themselves and their family. Picwell is available to consumers through insurers, exchanges, employers, agents, and brokers, and makes health plan recommendations using a sophisticated prediction of a person's health care costs for the upcoming year.

Consumers provide just their age, gender, zip code, and prescription medications. Picwell then accesses vast amounts of public and private data on utilization, demographics, lifestyle, behavior patterns, and client-specific data on plan offerings and claims history, and combines everything into

an analytical model that marries predictive analytics and personal preferences, such as the importance of customer satisfaction ratings and risk tolerance for high out-of-pocket costs. All told, it accounts for an incredible 900,000 variables involved in a health plan choice, an amount of information no person can reasonably understand and process.

The decision support tool provides consumers with three deliverables to guide them to a health plan choice. First, Picwell creates a "Picwell Score" and ranks plans according to their fit for the consumer's predicted utilization, value of the network, risk tolerance, and more. Then, for each plan, Picwell provides an estimated "RealCost," which combines premiums and projected out-of-pocket expenses. Finally, Picwell estimates how satisfied people similar to the consumer are with each plan to project a projected "Satisfaction Rating." Picwell says it has a 90% success rate in helping consumers choose a plan for their needs, and its tool helps consumers save nearly 20% by finding a plan that better fits their needs and reduces their risk of exposure to out-of-pocket costs.

PlanSmartChoice, Federal Employees Health Benefits Program

The Federal Employees Health Benefits Program (FEHBP), administered by the Office of Personnel Management (OPM), provides a wide selection of health plans to federal employees, retirees, dependents, and survivors. To assist consumers in choosing the right plan for themselves and their family, OPM provides decision support through an online tool called PlanSmartChoice. This tool, operated by Automatic Data Processing, Inc., is available to FEHBP members free of charge to assist in selecting medical, dental, and vision coverage as well as exploring the benefits of health savings accounts.

After entering an email address and answering some benefit eligibility questions, the site displays plans and rate available to the beneficiary. The site's Decision Center offers several tools to help beneficiaries choose the right plan. The

Preference Module requires an estimated 10 minutes to complete and provides a ranking of the health plans available based on the user's preferences. Preferences are determined first by asking beneficiaries to rate the importance of various plan features, such as premium, deductible, and out-of-pocket maximum levels. Second, the site presents several hypothetical tradeoffs and asks users to make a choice. One example is a choice between Plan A, with a $15 per pay period contribution and $2,500 deductible, or Plan B, with a $48 per pay period contribution and a $0 deductible.

The Medical Cost Calculator helps users estimate their total out-of-pocket spending, including premium costs, under each plan based on anticipated health care needs and takes about three minutes to complete. The Comparison Module allows beneficiaries to select plan features, such as monthly contribution, deductible, and access features like the need for referral to a specialist, and create a side-by-side comparison of plans. Finally, the Savings Account Estimator provides an illustration of how tax-advantaged accounts, such as a health savings account or medical flexible spending account, can benefit the user. Dental and vision plan comparison tools are also available. Beneficiaries must then visit their benefits enrollment website to effectuate their enrollment decisions.

Stride Health: California, New York, New Jersey, Florida, Texas, Illinois, and Pennsylvania

When Tommy Leep left his job at a Silicon Valley venture capital firm to start his own business, the 29-year-old knew he needed health insurance. Leep enjoyed playing soccer, running, and surfing, and knew an injury could be financially devastating. He checked out the plans available through Covered California, but couldn't easily determine which plans covered his doctor, what an injury would cost, and get an estimate of his total out-of-pocket costs. Then, Leep tried Stride Health, and within 10 minutes had a recommended plan and a good sense of his projected health care spending for the year ahead. He described the experience as "a lot like

TurboTax. It very simply walks you through what you need to do next."

Headquartered in San Francisco, CA, and operating in seven states, Stride Health offers both a "health insurance recommendation engine" and a private health insurance exchange. The company focuses on helping freelancers and other self-employed individuals, who typically have a hard time finding affordable coverage, choose the right plan for them. Stride has partnerships with businesses like Uber, Postmates, and TaskRabbit to help their contractors quickly find affordable health insurance. For example, Stride's recommendation engine is built into the Uber driver app, and Stride reports that 60% of their enrollments occur on mobile devices.

Consumers looking for health insurance may enter their zip code, age, gender, doctors, and medications, and Stride recommends a plan based on its health and financial forecast. This forecast, which users may view and edit to include more and/or different prescription drugs, or different health care utilization, estimates how much health care a consumer is anticipated to use in the next year and the cost of that care. Stride recommends the plan that saves consumers the most money on premiums and medical costs, and ranks other available plans accordingly. Consumers may view all plan details and immediately enroll in the recommended plan, or choose to view more plans, which are ranked.

Stride also offers a feature that allows users to "See this plan in action." Here, individuals may choose from 13 different health scenarios, ranging from strep throat to having a baby, or having a heart attack. The tool estimates the cost of such an event with health plan coverage and compares it to the cost of care without insurance. Consumers interested in learning whether they may qualify for premiums subsidies may provide their household size and income, and the site calculates premiums based on subsidy amounts. Finally, Stride offers a guide to health insurance that provides general information to help individuals better understand insurance.

The service does have a few drawbacks—Stride only displays plans with which it has contracts (it earns commissions) and those who qualify for premium subsidies can't get them through Stride.

California

Medi-Cal Managed Care

Medi-Cal beneficiaries receive fee-for-service coverage when they first qualify but are required to choose a health plan within 30 days. Medi-Cal chooses a health plan for beneficiaries who do not make their own selection within 30 days. In 16 counties that use geographic managed care or two-plan models of managed care, automatic assignment operates under a performance-based incentive program that considers health plan quality and cost. Plans in these counties are scored on several Healthcare Effectiveness Data and Information Set measures and safety net measures. Higher-quality plans receive a higher percentage of enrollment via automatic assignment. In addition, low cost plans receive a 5% increase in default enrollments, while default enrollments in high cost plans are reduced by 5%. The allowed percentage change in total automatic assignments is capped at 20%.

Florida

Darden Restaurants, Employees Nationwide

In late 2012, Florida-based Darden Restaurants, which operates the Red Lobster, Olive Garden, Longhorn Steakhouse chains, among others, announced it was moving its 45,000 active, full-time employees from its traditional PPO plan to Aon Hewitt's private exchange. Company executives sought to offer employees more plans than were previously available, and participation rates for employees and dependents increased in the exchange environment. To help employees select health coverage, plans offered on Aon's active employee exchanges must meet one of five standardized designs, which helps consumers make apples-

to-apples comparisons. Unlike plans offered on ACA Marketplaces, Aon's exchange plans must standardize additional plan design elements; all plans offered within a metal level must have the same co-payments and deductibles.

To further assist consumers in selecting a plan, Aon provides at least three decision support tools. One tool permits comparison of high-level details, such as premiums, deductibles, copayments, and other features, across plans, while another allows employees to search a plan's network for their preferred doctors and hospitals. A new tool, called New Help Deciding?, introduced just last year, uses a step-by-step decision process to help employees select a plan that aims to balance the employee's ability to pay for unexpected medical expenses with the desire to reduce payroll deductions.

In 2014, 86% of all employees using Aon's exchange used the side-by-side comparison tool during enrollment, up from 68% in 2013, and 66% used the network coverage tool, an increase of 9 percentage points from the previous year. In the first year that the Need Help Deciding? tool was available (2014), 64% of employees used it. Additional support is available from trained call center staff.

Illinois

Sears Holdings Corp., Employees Nationwide

For the 2013 benefit year, Illinois-based Sears moved active employees from a self-funded health plan to a fully-insured, defined contribution model, with plans available via a private exchange operated by Aon Hewitt. After three open enrollment periods using the private exchange, Sears Chief Human Resources Office Dean Carter reports an interesting evolution in employee plan choice: In year one, employees chose plans that looked like their previous plans. In year two, they shopped based on premium price. But, in the third year, they chose plans that offered the highest value. And, even in

that first year, when employees chose plans that resembled their previous plans, Sears saved $38 million.

Aon's exchange helps employees choose the highest value plan in a number of ways. First, like the Affordable Care Act's health insurance Marketplaces, plans offered on Aon's active employee exchanges must meet one of five standardized designs, which helps consumers make apples-to-apples comparisons. Unlike plans offered on ACA Marketplaces, Aon's exchange plans must standardize additional plan design elements; all plans offered within a metal level must have the same co-payments and deductibles.

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Walgreens, Employees Nationwide

In 2014, Illinois-based Walgreens moved its 160,000 employees from a self-insured plan with two plan options, to a fully-insured defined contribution model with up to 25 plan choices available to employees, depending on where they live. In the first open enrollment through the exchange, Walgreens reported an "overwhelmingly favorable response"

from employees regarding the enrollment process and the plan choices available. And Walgreens is helping its employees make an informed plan choice by offering a number of decision support tools through Aon Hewitt's exchange. Plans must meet one of five standardized designs, including standardized copayments and deductibles within a metal level, which helps consumers make apples-to-apples comparisons. To further assist consumers in selecting a plan, Aon provides at least three decision support tools. One tool permits comparison of high-level details, such as premiums, deductibles, copayments, and other features, across plans, while another allows employees to search a plan's network for their preferred doctors and hospitals. A new tool, called New Help Deciding?, introduced just last year uses a step-by-step decision process to help employees select a plan that aims to balance the employee's ability to pay for unexpected medical expenses with the desire to reduce payroll deductions. In 2014, 86% of all employees using Aon's exchange used the side-by-side comparison tool during enrollment, up from 68% in 2013, and 66% used the network coverage tool, an increase of 9 percentage points from the previous year. In the first year that the Need Help Deciding? tool was available (2014), 64% of employees used it. Additional support is available from trained call center staff.

Massachusetts

One Care: Mass Health Plus Medicare

Massachusetts was the first state to finalize an agreement with the Centers for Medicare & Medicaid Services to test a capitated financial alignment model for beneficiaries eligible for both Medicare and Medicaid. The program, One Care: Mass Health plus Medicare, uses a default choice mechanism to help beneficiaries select one plan that provides person-centered, comprehensive benefits. After a period of voluntary enrollment, Massachusetts automatically assigned beneficiaries to a default plan during one of four rounds of assignment throughout the first year of implementation. This automatic assignment only occurs for qualifying

beneficiaries who live in counties in which two or more One Care plans are available. Following auto-assignment, beneficiaries were free to choose a different One Care plan or to revert to their prior Medicare and Medicaid options.

As of June 2015, 17,705 dual eligible beneficiaries were enrolled in one of three One Care plans. Approximately 60% of these beneficiaries were automatically assigned to a One Care plan. MassHealth uses "intelligent assignment," conducted by an enrollment assignment expert rather than an algorithm, to assign beneficiaries to a OneCare plan. The process involves analysis of MassHealth claims data to identify a beneficiary's pre-existing provider relationships with the goal of assigning the beneficiary to a plan that contracts with these providers. A recent survey of One Care beneficiaries found no significant differences between voluntarily and passively enrolled beneficiaries in satisfaction with their care team and plan and intention to stay in One Care.

Minnesota

Orion Corporation

Mike Sarafolean was fed up. The CEO of St. Paul-based Orion Corp., a 70-person firm providing services to individuals with disabilities, received a plan renewal notice that included a 40% premium increase. This was following years of double digit premium increases. So, in 2011, Sarafolean sent his employees to a private exchange operated by Bloom Health. Headquartered in Minneapolis, Minnesota, Bloom Health offers a private exchange technology platform for employers with more than 50 employees. Nearly 250 employers headquartered in 24 states and with employees nationwide use the technology. Bloom partners with insurers, employers, and agents to offer its technology to consumers, and the platform accommodates defined benefit or defined contribution models as well as full insured or self-funded plans. Sarafolean chose to switch to a defined contribution model and appreciates that fact that, rather than trying to

buy one plan that works for most of his employees, workers may now select the plan that's right for them.

To help employees select a plan, Bloom offers both online and one-on-one decision support to help consumers choose the best plan for them. Online support includes a 5-minute, 15-question survey regarding consumers' finances, risk tolerance, and health care utilization. For example, consumers are asked to complete the phrase "when we get sick…" by choosing from options ranging from "we use home remedies or over-the-counter medication" to "we usually end up in urgent care of the emergency room." Using the survey results, Bloom creates a user profile called "Our View of You" and suggests several plan options, flagging plans that it considers a "great match" and including high-level plan design comparison. Consumers may also reach a live, licensed Advisor, via phone or email, who not only helps guide individuals to the right plan for them, but also has input into product design to ensure plans reflect consumer demand. Bloom reports that employees who use Advisors to select a plan report have a 95% satisfaction rate.

Gabrielle Smith, a long-time Orion employee, couldn't have been more pleased with the change. Smith suffers from an auto-immune disease and worried she wouldn't be able to get insurance or be able to afford insurance if it was offered – remember, this was before guaranteed issue took effect. But, Smith found a plan with a lower deductible than her previous Orion plan that, at the time, cost her just $45 per month.

Missouri

MO HealthNet Managed Care

MO HealthNet Managed Care operates in three regions of the state, which together cover 53 of the state's 114 counties and the City of St. Louis. Beneficiaries in counties not included in managed care remain in fee-for-service Medicaid. Within these three regions, most individuals eligible for Medicaid are required to participate in managed care and select a managed care organization. Most beneficiaries have 15 days from the

time of eligibility determination to select a plan, and all family members are encouraged, though not required, to select the same plan. If a plan is not selected, one is automatically assigned. The first steps in the automatic assignment process consider whether the beneficiary or any family members are already enrolled with a managed care organization and assigns the beneficiary to that plan. If not, beneficiaries are assigned to a plan at random, with 40% of random assignments within a region shared equally among the plans, and 60% of random assignments based on plan performance, with higher-performing plans receiving more beneficiary assignments. Following initial plan selection or automatic assignment, beneficiaries have 90 days to change plans for any reason. After 90 days, beneficiaries may change plans under certain conditions, such as moving out of the service area or a primary care provider no longer participating with the plan, and beneficiaries have an annual, 30-day open enrollment period.

Nebraska

Medicaid

Certain beneficiary groups are required to participate in Nebraska's physical health Medicaid Managed Care Program. Beneficiaries have 15 days from recent of their Client Guidebook to select a managed care plan and primary care provider. Two plans are available in each two regions of the state, and client guidebooks provide information to help beneficiaries select a plan, including benefits, participating providers, referral process, special programs, and more. Beneficiaries who do not select a managed care plan and primary care physician within the 15 day initial enrollment period are automatically assigned to both. The state's automatic assignment process prioritizes enrolling all eligible family members in the same managed care plan and gives priority to provider-beneficiary proximity. The system further attempts to distribute enrollment evenly between the two health plans in each region. Following enrollment or automatic assignment, beneficiaries have 90 days to change

plans for any reason and then may change plans once per year during an enrollment window around their eligibility anniversary. Opportunities to switch plans outside the annual enrollment period may be available to beneficiaries for "good cause."

New Jersey

NJ FamilyCare

New Jersey's Medicaid expansion program, called NJ FamilyCare, provides health coverage through managed care organizations. Between two and four managed care organizations are available in each county, and enrollment in a health plan is mandatory. However, the state does not employ automatic assignment for NJ FamilyCare beneficiaries. Instead, beneficiaries do not have coverage for medical services until they select a managed care organization. Most NJ FamilyCare beneficiaries may change plans within the first 90 days of enrollment and have an annual opportunity to select another plan. Beneficiaries who demonstrate "good cause" may have additional opportunities to transfer to another plan.

Pennsylvania & New York

Alcoa

Jim Sams, a 66 retiree from Scott, Pennsylvania, who worked for Alcoa for 42 years, greeted news with relief that his former employer was moving salaried, non-union retirees to a private exchange to shop for health insurance. "I came out of the meeting feeling a lot better. What they showed here today was less expensive than the Alcoa option," Sams said. The aluminum maker provides supplemental coverage when retirees become eligible for Medicare, and will give retirees a set amount of money with which to purchase Medigap, Part D, or Medicare Advantage coverage through OneExchange, a private exchange operated by Towers Watson. Some retirees, like Sams, had previously left the company-administered plan for the private market due to rising premiums, and

Alcoa's analysis found greater benefits at lower costs for retirees through the exchange. Many retirees interviewed following initial informational meetings about the change felt positive regarding their ability to save money, saying the options available through the exchange cost less than the Alcoa-administered option. The OneExchange platform provides decision support through its Help Me Choose feature, where users may provide information regarding their health status, need for care outside their home area or internationally, a preference for either lower premiums/high copayments or higher premiums/minimal copayments, and enter their prescription medications. The tool then recommends whether consumers should select original Medicare, coupled with Medigap and Part D plans, or Medicare Advantage, but does not recommend a specific plan. Consultation with a licensed benefit advisor is available via phone, and the exchange also provides general information to help users understand Medicare.

Virginia

Hilton Worldwide, Employees Nationwide

Ted Nelson, vice president of benefits for the Americas, was highly skeptical about moving the hotel chain's U.S. employees to a private exchange. The firm had already taken actions, such as closed provider networks and drug formularies, to reduce benefit costs, and Nelson wasn't convinced a private exchange was the right choice for his firm and Hilton's employees. But, he says, the move "worked despite my skepticism." For the 2014 plan year, Hilton faced an anticipated benefits cost increase of 8% per team member, but the move to Aon Hewitt's private exchange yielded a decrease of 1% without any reduction in plan benefits or employer contribution. Second year renewals came in at a competitive 5.3% increasing, ensuring Hilton can continue leveraging its initial savings.

But the firm isn't just saving money—employees are highly satisfied with the move. Eighty-four percent of employees like being able to choose their own insurer and associated network, and 76% said Aon's site made it easy to compare options and enroll. To help employees make apples-to-apples plan comparisons, Aon requires plans to meet one of five standardized designs, including standardized copayments and deductibles within a metal level.

To further assist consumers in selecting a plan, Aon provides at least three decision support tools. One tool permits comparison of high-level details, such as premiums, deductibles, copayments, and other features, across plans, while another allows employees to search a plan's network for their preferred doctors and hospitals. A new tool, called New Help Deciding?, introduced just last year uses a step-by-step decision process to help employees select a plan that aims to balance the employee's ability to pay for unexpected medical expenses with the desire to reduce payroll deductions.

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