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The Episode-based Benefit Plan

Promoting Episode-based Provider Payment Through Employee Health Benefit Design

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Executive Summary

Employers sponsoring group health plans face the ever-growing challenge of rising health care costs, and the increasing expenses they place on the plans and their enrollees alike. To respond to these pressures, employers have experimented with a variety of insurance design options and payment models, to varying degrees of success, mostly modest. However, research and field implementations show that episode-based payment arrangements present an opportunity to stem these rising costs, while increasing the coordination of care in the fragmented US health care system. In these models, plans and groups of providers agree to a flat fee for all services related to a single episode of care. The providers then work within that budget in a coordinated way to deliver cost-effective and quality care.

To achieve the full potential of episode-based payments, plans and providers must align their goals and incentives with those of the employees (and patients) they serve. The typical employer-sponsored group health plan design today is not calibrated to encourage patients to select the highest quality or most efficient providers, and does not reward patients for selecting a provider who will deliver care at a single episode-based price.

Employers can design creative cost-sharing frameworks that give enrollees financial incentives to join with employers and episode-of-care contracted providers ("EOC contracted providers") in promoting the episode-based care model. This paper describes just such a framework: the Episode-based Benefit Plan.

In the Episode-based Benefit Plan, patients are rewarded with low cost sharing and a predictable price for an entire episode of care when they select a high-value EOC contracted provider. Their cost-sharing obligations increase as they move to more expensive EOC contracted providers. And enrollees who decline to use EOC contracted providers may face even higher cost-sharing obligations for the individual services they utilize, some of which might not accrue toward their annual maximum out-of-pocket cost-sharing limits. Coupled with strong transparency and patient education tools, this simple framework of cost sharing can motivate patients to make wise health care choices that benefit themselves, plans and providers alike.

Introduction

Why an Episode-based Benefit Plan?

As health care costs grow nationwide, employers are increasingly driven to manage these increases through higher employee cost sharing. Employee out-of-pocket spending for employer-based PPO coverage increased nearly 70% over the past decade.[1] Such high cost sharing presents financial barriers that can lead patients to forgo both high- and low-value health care.[2] Avoidance of necessary and preventive services can, in turn, lead individuals to experience poorer health outcomes and eventually require more costly emergency services and inpatient care. Another means of addressing increasing health care costs is network restrictions. According to the 2020 Health Care Delivery Survey by Willis Towers Watson,[3] a benefits consultancy, close to one in five employers had implemented a narrow network in one or more regions where they have concentrations of employees. These narrow networks are designed to address the price of care, but not its utilization and, by their nature, restrict the choice of providers for plan enrollees.

Bundled programs, or episode-based payment programs, have grown in popularity as health care payers seek to improve care coordination while lowering costs and as an alternative to simply increasing cost sharing or narrowing networks. In contrast to traditional fee-for-service (FFS) models, where payers make separate payments for each service a patient receives, episode-based payments offer providers a single payment to perform a set of services within defined bundles or episodes. Providers who have agreed to this predetermined rate accept some financial risk for the cost of the services and are incentivized to deliver more efficient care. In 2016, the Center for Medicare and Medicaid Innovation (CMMI) tested episode-based payment through the Comprehensive Care for Joint Replacement (CJR) model and found costs for model participants were about 5% lower than the baseline.[4] The federal government is continuing to build on this success, announcing its intention to move more patients to similar accountable care relationships where providers are "responsible for managing patients' care and are accountable for their patients' costs."[5]

However, innovation is needed to fully realize the potential of episode-based payments and ensure patient access to necessary services, all the while avoiding unnecessary network restrictions and high cost-sharing arrangements. To date, the episode-of-care model has existed largely as an arrangement between plan and provider. While patients benefit from the improved care coordination offered by episode-based payments, they rarely share in their financial benefits. As a result, patients are not financially motivated to participate in the success of episodes through provider selection or adherence to treatment recommendations. Even if they were financially motivated, oftentimes patients do not have sufficient information readily available to make an informed choice. Financial barriers to seeking care can persist as well, with high deductibles presenting barriers that discourage all patients from seeking needed care, with disproportionately high adverse impact on racial and ethnic minorities.[6]

Studies show financial incentives are most powerful in improving patient conditions when they target both patients and providers, rather than one or the other in isolation.[7,8,9] Therefore, to maximize the effects of cost sharing on patients' health and improve the efficiency of care, plans should financially incentivize patients and providers together to strive toward the same outcomes. This combination of value-based payments and

value-based insurance design is what has been recently recommended by VBID Health in a new white paper, "The Essential Role of Employers in Aligning Plan Design and Payment Reform to Improve Quality, Enhance Equity, and Promote Value,"[10] authored by Drs. Fendrick, Chernew and Levin-Scherz.

Our Approach

This white paper describes an approach to episode-based payments for self-funded employers that can remove barriers to high-value health care by aligning patients' OOP responsibilities with the value of a covered episode—for example, lower OOP responsibility for a chronic condition and higher for an elective procedure. The Episode-based Benefit Plan could be the sole plan offering for some or all employees, or it could be one of several plan choices where the employer prefers that approach. In either case, the considerations discussed in this white paper envision an underlying health plan that covers non-episodic care and addresses many standard plan features, including covered services and network arrangements. In that context, the Episode-based Benefit Plan offers cost-sharing options and price and quality transparency tools for patients, which can together serve as levers to encourage enrollees to visit providers offering high-value services at a lower price and discourage low-value care, helping reduce health care costs while ensuring patients receive the care they need.

The Episode-based Benefit Plan uses cost sharing, price transparency, and quality measures to align financial incentives for patients, with the financial arrangements negotiated between plans and providers. Through the Episode-based Benefit Plan, plan enrollees are offered a prospectively defined budget for each episode of care whether offered by an EOC contracted provider who has agreed to perform all services within the episode at a predetermined rate or a non-EOC contracted provider whose full episode price would only be known after the end of the episode. By reviewing the price of the EOC contracted provider, the member understands their financial obligations upon selection. Members who choose to see non-contracted providers for episode-related care will not have the same price transparency available and will subject themselves to uncertainty and potentially higher OOP costs. Further, the Episode-based Benefit Plan is designed to vary based on the employer's underlying plan type to maximize enrollees' incentives to seek higher-value care and participate in cost-saving behaviors. Combined with preventive care and opportunities for wellness benefits, the Episode-based Benefit Plan is a comprehensive benefit package that encourages enrollees to affordably and efficiently get the care they need in a manner that aligns with their employer's and providers' financial arrangements.

The particulars of each employer's current plan will differ, and as a result, so too will the final Episode-based Benefit Plan that it transforms into. This paper provides several options for employers to address differing needs. In order to illustrate how an Episode-based Benefit Plan might work, the paper provides a detailed example of how cost sharing could be tiered in a benefit plan to incentivize enrollees while also addressing actuarial and regulatory considerations.

In the example plan, enrollees whose health needs fall into an episode of care face a tiered cost-sharing model, with rates of cost sharing increasing as health care costs accumulate. Those enrollees who select an EOC contracted provider pay coinsurance based on the fixed price of the episode that is known to them in advance, and that likely falls into a lower cost-sharing tier. Consequently, their coinsurance obligation will be less when they select a lower-cost provider for the episode of care. Meanwhile, enrollees whose health needs

fall into an episode of care and who do not select EOC contracted providers will be subject to the same tiers of cost sharing based on the actual accumulated provider charges (as allowed by the underlying plan) for the individual services incurred in each tier. As these unpredictable individual charges accumulate, the enrollee's cost sharing rises. But the plan's liability is capped relative to the price of the episode at a maximum allowable, with all costs above the maximum allowable borne by the enrollee, meaning these enrollees could pay a high out-of-pocket cost for choosing to use a non-EOC contracted provider.

Milliman, an actuarial consulting firm, has used this approach as the basis for its accompanying actuarial model.

This paper takes into consideration the specific regulatory constraints placed on self-funded group health plans, mostly under federal labor, tax and health care regulation. Every employer's circumstances may differ, and employers should consult their advisors to ensure compliance.

Designing the Episode-based Benefit Plan

General Considerations About Episodes

At the foundation of the Episode-based Benefit Plan is each episode of care and the comprehensive payments for them that plans pay to providers.

A single episode of care comprises all care for a health event, such as maternity and childbirth or a knee replacement, or maintenance care for a chronic condition such as back pain or diabetes. Each of these episodes is defined in detail, with clear demarcation by procedure type or code as to which services are considered related to the health event and included in the episode and which are not. Episodes are also assigned clear "trigger" events, such as a diagnosis or a specific procedure that indicates an episode of care is occurring. And episodes are time-limited; for example, an episode that revolves around a surgical procedure might encompass all included services from 30 days before the episode trigger through the 90th day following the episode trigger. An episode that involves the management of a chronic condition might encompass all services within a calendar year.

Bundling services by episode enables an episode-of-care payment model, also referred to as value-based or bundled payment. Rather than being paid on a fee-for-service basis for each individual service that occurs during an episode, in an episode-of-care payment model, a provider or group of providers who deliver the care for an episode agree to accept a single fixed price for all services included in the episode. For example, an ambulatory surgical center, an orthopedist, an anesthesiologist and a rehabilitation center might join together to accept a fixed price for a knee replacement.

Episodes bring together plans and providers and allocate financial risk. The plan and the providers typically negotiate an agreed-upon price for an episode (the provider-specific episode price). The episode price takes past performance into consideration and can include the expected benefit of performance improvement

opportunities made possible through improved decision-making and care coordination by the provider in charge of the episode. Individual episode prices can be risk adjusted based on specific health characteristics of a patient to capture potential variability in expected utilization.

Having agreed on the episode price, once an episode is triggered, providers who then manage the care of the patient within that episode price are accountable for both cost and quality. Different groups of providers may negotiate for a different episode price, allowing patients to shop and select between them on the basis of value. Providers may align in groups to deliver the care, and allocate the funds in the episode price between them. If there is "leakage" from the episode, and providers who have not agreed to accept the episode price perform some services that are included in it, that amount is deducted from the EOC contracted providers' payment. In this way, payments for episodes align incentives across stakeholders and incentivize evidence-based, cost-effective care.

Pricing can and should be structured to incentivize quality improvement by conditioning full payment of the negotiated episode price on providers achieving episode-specific quality metrics. In this way, the model guards against a reduction in needed care by focusing incentives on reducing inappropriate care. It also rewards measurable improvements in patient outcomes.

Similar approaches to episode-based payment have proliferated in government programs with the Medicare Bundled Payment for Care Improvement Advanced model, which covers billions of dollars in payments, and statewide Medicaid episode-of-care programs. In addition, companies such as GE, Walmart, Lowe's and Boeing are directly negotiating with providers for episodes of care.

From a plan design perspective, one key feature of episode-based payments is that the episode price can set a single "allowed amount" for all care within the episode for cost-sharing purposes. Rather than calculate enrollee coinsurance on each individual service rendered within the episode, the plan can calculate cost-sharing responsibility on the episode price itself.

Episode-based Benefit Plan Cost Sharing & Reward Structure

The Episode-based Benefit Plan is built around a novel and nuanced cost-sharing design that encourages smart and efficient enrollee behavior. Cost sharing is the lever that helps motivate enrollees to choose high-quality and efficient EOC contracted providers over others of lower quality and lower efficiency. And it is the means by which enrollees can share in the savings that employers are earning from episode pricing. It is also the lever that can encourage the use of high-value services from high-quality providers while discouraging the use of lower-value services from lower-quality providers.

Once an enrollee's care falls into an episode, the Episode-based Benefit Plan's special cost-sharing advantages can take effect.

There are many "dials" an employer can adjust in order to incentivize and reward enrollees for selecting a provider who has contracted at an episode-based rate, for avoiding less-efficient non-EOC contracted providers and for picking high-value services over lower-valued ones.

The Episode-based Benefit Plan relies on three main categories of "dials" that employers could use to create a balanced program of incentives. Each of these can be finely tuned to create a plan that best meets an employer's needs:

The Episode-based Benefit Plan relies on three main categories of "dials" that employers could use to create a balanced program of incentives.

- In-Episode Cost Sharing Dials: These are the familiar elements of any plan, constituting the enrollee's out-of-pocket costs for health care services. Deductibles, copays and coinsurance are most often used here.
- Episode-Specific Pricing Dials: Each episode will have specific cost-sharing parameters determined by the expected costs of care in that episode. These parameters are:
  - The episode budget: A preset budget for each episode of care toward which enrollees can accumulate costs at preferential cost sharing.
  - The episode "maximum allowable": Like a reference price, it represents the most a plan will pay under ordinary circumstances for an episode.
  - A stop-loss threshold: An episode-specific cap on an enrollee's out-of-pocket costs.
- Incentives: Cash payments or equivalents shared with enrollees for using EOC contracted providers. This could include sharing savings when an enrollee chooses an EOC contracted provider with a price below the episode budget.

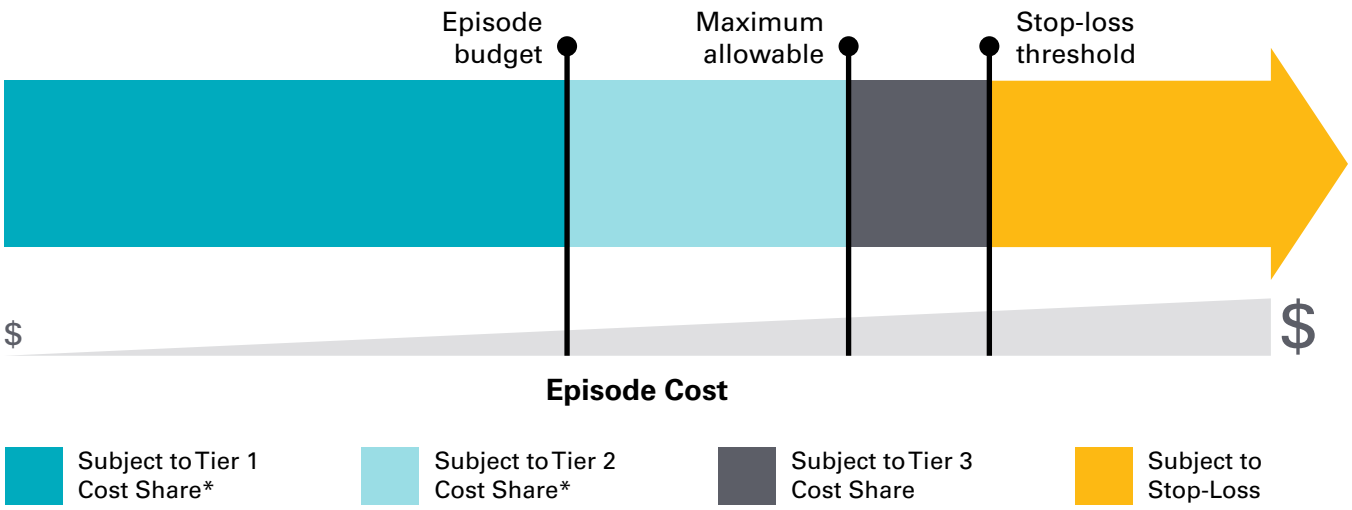
A Three-Tiered Approach to Using the Cost-Sharing Dials

Putting these principles into practice, a three-tiered cost-sharing approach can effectively incentivize enrollees in the Episode-based Benefit Plan.

Episode-based Benefit Plan Glossary:

- **EOC contracted provider:** A provider who has accepted risk for the cost of care associated with services in an episode.
- **Episode price:** The amount an EOC contracted provider is paid for an episode; can vary by provider and is unknown for non-EOC contracted providers.
- **Episode budget:** A prospectively set budget for each episode that patients can accumulate the cost of episode care toward, and below which cost sharing is most favorable; episode prices can be above or below the episode budget.
- **Maximum allowable:** The most a plan will pay for an episode (except in catastrophic/outlier cases).
- **Stop-loss threshold:** A predefined cap on an enrollee's out-of-pocket costs within an episode beyond which the plan covers all costs.

Figure 1. Proposed Episode Cost-Sharing Design for EOC Plan



* Applies up to the provider contracted rate for EOC-contracted providers (if lower than the episode budget or maximum allowable).

This three-tiered approach applies to the allowable costs an enrollee incurs in an episode, whether those costs are a provider's single episode price or the accumulation of fee-for-service charges incurred when an enrollee decides not to see an EOC contracted provider. Either way, the enrollee's cost sharing climbs up the tiers as costs increase. The advantage to an enrollee of selecting an EOC contracted provider lies in the predictability of cost sharing, and potentially lower prices.

A three-tiered cost-sharing approach can effectively incentivize enrollees in the Episode-based Benefit Plan.

Tier 1 is the most favorable to the enrollee. It represents the cost-sharing enrollees pay when they visit an EOC contracted provider who has agreed to accept a fixed episode price at or below the enrollee's episode budget. This tier applies to related costs up to the episode budget set by the plan regardless of the provider's negotiated price. In this tier, cost sharing is lowest, perhaps as low as 0%. This low cost-sharing simultaneously encourages enrollees to seek in-episode care and to select providers offering lower episode-of-care prices. When an enrollee selects a fixed-price EOC contracted provider, the cost sharing is predictable for the entire episode; for all care up to the episode budget, the enrollee pays Tier 1 cost sharing. In cases where the episode budget is below a specific provider's negotiated episode price, the enrollee would pay cost sharing on the excess under Tier 2.

Tier 2 is still advantageous, but less so. It represents the additional cost-sharing that enrollees pay when they pick an EOC contracted provider offering a higher episode price than the episode budget, or when the total costs incurred by non-EOC contracted providers go above the episode budget. In this tier, the enrollee's cost-sharing percentage should be higher than in Tier 1. For an illustrative example, Tier 2 may range from 5% to 30%. The coinsurance rate is charged only on the marginal costs above the episode budget. So, the enrollee who chooses an EOC contracted provider whose episode price is over the episode budget still enjoys a fixed

predictable cost-sharing obligation (though a slightly higher one). As in Tier 1, some providers' episode prices may exceed the top of Tier 2, known as the maximum allowable, or the costs incurred with non-EOC contracted providers goes above the maximum allowable.

One additional feature in our three-tiered model is that cost sharing in Tiers 1 and 2 accumulate against the enrollee's out-of-pocket maximum.

Tier 3 is the least advantageous. Having reached the maximum allowable for an episode, which represents the most a plan will pay for an episode of care (or, more precisely, the most a plan will pay under favorable cost sharing), the enrollee should now be responsible for a significantly higher percentage of cost sharing as claims accrue. For an illustrative example, cost sharing in this tier could range from 50% to 100% of all costs. Cost sharing could continue without any cap, but the three-tiered approach illustrated does include a stop-loss threshold, at which point cost-sharing obligations cease. Up to that threshold, however, cost-sharing above the maximum allowable (e.g., in Tier 3) does not accrue toward the enrollee's overall out-of-pocket maximum.

For enrollees who do not pick EOC contracted providers but whose care has triggered an episode, cost-sharing obligations accrue as individual claims are processed and are paid at either the negotiated rate or, for out-of-network claims, at the plan's allowed amount for individual services. Claims costs up to the episode budget incur cost sharing at the Tier 1 rate. Claims costs above the episode budget incur cost sharing at the Tier 2 rate. And claim costs above the Maximum Allowable incur Tier 3 cost sharing. Moreover, because the enrollee has selected a non-EOC contracted provider, the enrollee does not benefit from predictability of costs.

Overall, the three-tiered approach to cost sharing in an episode has three main components:

Cost-Sharing Depends on Episode's Triggering: When an enrollee is eligible for an episode, they receive an episode budget and cost sharing is based on the way in which the three tiers described above have been set for that episode. When an enrollee receives care that is not part of a triggered episode, their cost sharing is based on the individual allowed amounts of the various covered services they use and the underlying plan design.

Cost-Sharing Increases as Episode Prices or Costs Increase, Up to a Cap: Enrollees who visit EOC contracted providers will enjoy a low, predictable price with a fixed cost-sharing obligation. But enrollees who opt not to see EOC contracted providers will face a potentially higher cost-sharing obligation without the benefit of a predictable fixed price. Either way, enrollee liability is capped at the stop-loss set for each episode.

Cost-Sharing Varies by Episode Type: Consistent with the principles of value-based insurance design, the cost-sharing percent set at Tiers 1, 2 and 3 can vary based on the episode type. For example, condition episodes, especially chronic conditions, should have low or no cost-sharing at Tier 1 and low cost-sharing at Tier 2. Conversely, some procedural or acute episodes, such as one for a spinal surgery for pain, have been identified as being low-value procedures; these could have higher cost-sharing at Tiers 1 and 2 to emphasize

that the procedure may not always be appropriate and that the employee should choose wisely.[11] Depending on the point at which an employer sets the maximum allowable, as described below, the cost-sharing percentage for Tier 3 can be similarly nuanced to encourage high-value care and discourage lower-value care.

This approach is not the only way of adjusting cost-sharing for an episode of care. But it has significant advantages over simple changes to deductibles or cost-sharing percentages. By tiering the cost-sharing, the plan is able to recognize the difference between the varying prices charged by EOC contracted providers. And it takes advantage of the episode price as a single, predictable allowed amount.

> Condition episodes, especially chronic conditions, should have low or no cost-sharing at Tier 1 and low cost-sharing at Tier 2.

Episode Pricing

Setting the episode budget, the maximum allowable and the stop-loss threshold depends on employer preferences within actuarial constraints. These parameters can be adjusted for each episode, making the plan more or less generous in order to balance the actuarial value of the plan overall with the objectives of value-based insurance design.

Generally speaking, setting the maximum allowable below the 50th percentile of episode prices will expose plan enrollees to significant cost-sharing, which is not the intended purpose of the plan.

Overall, employers should consider whether the maximum allowable should be a generous ceiling, allowing broad latitude to select higher-cost providers, or should be set near (or at) the episode budget, to further encourage more judicious selection of lower-priced providers. This, along with cost-sharing options, will have the largest effect on the actuarial value of the plan design.

> Setting the maximum allowable below the 50th percentile of episode prices will expose plan members to significant cost-sharing.

It's also important to consider setting each individual maximum allowable in such a way that having one episode of care does not trigger such extensive out-of-pocket costs in Tiers 1 and 2 as to place the enrollee above the plan's out-of-pocket maximum. This way, when enrollees experience multiple episodes, the financial incentives for each episode will maintain the intended behavioral effect.

Finally, by convention, the stop-loss threshold for most episodes could be set at the 95th percentile of the episode cost (including cost of all associated claims). However, employers could consider a lower threshold for higher-priced episodes, which are typically inpatient procedural episodes. These procedural episodes often have higher costs overall, meaning a patient could have a higher liability in absolute terms (not subject to the out-of-pocket maximum) if the stop-loss threshold is not reduced.

HDHP Considerations & Flat Incentives

When the underlying health plan is a high-deductible health plan (HDHP), the cost-sharing related constraints of HDHPs may make it difficult to layer the Episode-based Benefit Plan atop it. Instead, employers might consider using the Episode-based Benefit Plan as an actuarially equivalent but superior alternative to an HDHP plan.

Many employers have adopted HDHPs as a solution to increasing health care costs. But the effect of this strategy is to shift these increasing costs to enrollees. And the high-deductible design discourages enrollees from obtaining needed care by requiring them to make large up-front deductible payments before plan coverage will help them. Employers can reverse this trend by adopting an Episode-based Benefit Plan that is actuarially equivalent to their current HDHP design, but that offers their enrollees low, predictable cost-sharing for high-value services without the need for a prohibitive out-of-pocket deductible.

Employers who choose to retain their HDHP plan will face some limitations in implementing an Episode-based Benefit Plan, but could still do so. In order to permit enrollees in the plan to make tax-favored contributions into a Health Savings Account in connection with an HDHP, an HDHP may not have a deductible lower than $1,400 for self-only or $2,800 for family coverage. To remain compliant with this limit, employers cannot create an Episode-based Benefit Plan, layered atop an HDHP, that has no cost sharing on the first dollar of coverage for an episode of care. For most services, employees must first satisfy their deductible before plan payments take effect. This may blunt the impact of the Episode-based Benefit Plan's nuanced cost-sharing design on enrollee behavior.

Alternative Cost-Sharing Structures

There are other options for cost-sharing structures that have more modest reach and lower complexity than our three-tiered approach.

For example, plans could eliminate or lower the plan's deductible when an enrollee picks an EOC contracted provider. Or plans could offer lower cost-sharing for use of EOC contracted providers, without demarcating an episode budget.

However the cost-sharing is designed, plans should bear in mind that once an episode of care is defined and EOC contracted providers are selected, use of episode providers and any agreed upon pricing of episodes should drive cost-sharing rules in order to avoid any type of cost-sharing that is based on accrual of individual services.

Selecting Episodes

To launch an Episode-based Benefit Plan, employers must first decide which particular episodes the plan will pay for at an episode-based rate.

Selecting episodes carefully is important to achieve employers' goals of reducing health plan costs and driving increases in quality. Having a clear set of principles for how episodes will be selected, as discussed further below, not only guides thoughtful decision-making but can also serve to give assurance that the plan is compliant with obligations such as parity in coverage of mental health services. Key considerations could include the relative price of different episodes, the cost savings and improved health outcomes achievable in those episodes, and the availability of high-quality providers willing to contract for specific episodes at competitive prices.

Having a clear set of principles for how episodes will be selected not only guides thoughtful decision-making but can also serve to give assurance that the plan is compliant with obligations such as parity in coverage of mental health services.

Generally speaking, and as further demonstrated in the Milliman actuarial model, the accretion of savings and the ability for the employer to end up with a new plan that has an equal or better actuarial value is predicated on engaging employees with a large portfolio of episodes.

Beyond selecting episodes, employers should consider designating certain episodes as "high value," for which they will offer reduced cost-sharing as an incentive, and "low value," for which they will have higher cost-sharing to dissuade use. High-value services are those whose clinical effectiveness is established, and whose benefits are proportional to their costs. Low-value services are those that provide little or no benefit to patients, have potential to cause harm, incur unnecessary cost to patients or waste limited healthcare resources.[12] For example, and consistent with current and past work from VBID Health, cost-sharing for procedural episodes such as spinal fusion should be higher than cost sharing for conditions such as diabetes.

Selecting One or More "Base" Plans for Non-Episode Care

Much of the covered care that enrollees receive in a year will not be included in episodes. Episodes cover a predefined set of services and do not cover other care, such as a sprained ankle, a cold or a stomach flu, that might require medical treatment but not care so extensive as to warrant bundling into a single fixed episode price. In addition, episodes typically do not include trauma-initiated care.

That is why this white paper envisions an Episode-based Benefit Plan that can be layered on top of one or more underlying or "base" health plans that cover non-episode care and that address many standard plan features. For cost-sharing purposes, the base plan must have a program of cost-sharing to identify the enrollee's out-of-pocket costs for individual services that resembles a traditional plan, with cost-sharing rates identified for each individual service on a fee-for-service basis. This base plan could be an existing employer plan, or it could be a new (yet still traditional) plan of benefits adopted as part of the transition to the Episode-based Benefit Plan. In either case, the unique cost-sharing mechanisms for episodes of care would function as a feature that is overlaid and integrated with a traditional health plan.

This approach has several advantages. Rather than needing to design a plan from scratch and to address all the complexities inherent in such a project, an Episode-based Benefit Plan framework can build on the platform of a traditional health plan. Features of the plan such as covered services and appeals processes will remain the same whether an enrollee is in an episode of care or not, saving employers time and effort by not having to redesign them for episodes. Enrollees will already be familiar with the general functioning of a base plan, so they'll need only to understand the new episode payment feature.

Employers might consider certain enhancements to their "base" plan, to support the implementation of the Episode-based Benefit Plan features. These could include reducing cost-sharing for primary care to encourage enrollees to establish care with high-quality primary care physicians who are enlisted in the episode-based payment effort. For example, the plan could offer office visits at $0 cost-sharing when enrollees are seen by a provider who will accept episode prices once triggered. Employers could further strengthen their relationships with these providers by arranging a population health-based payment to support advanced primary care efforts. This way, the enrollee is already aligned with an episode-contracted physician who can guide that enrollee to other in-episode high-quality providers if an episode is ever triggered.

Employers may wish to add the Episode-based Benefit Plan feature to all health plans offered to similarly situated employees. In this case, enrollees are automatically eligible for the episode-based cost sharing when they enroll in any such health plan during the normal annual enrollment process. Alternatively, employers may want to offer the Episode-based Benefit Plan as an added feature to some, but not all, plan types offered to a group of enrollees. In that case, only enrollees opting for the specified plan types will enjoy access to the Episode-based Benefit Plan's cost-sharing advantages. There also may be circumstances where an employer might only implement the Episode-based Benefit Plan in specific regions. See our discussion on networks below.

Episode-based Benefit Plan Can Differ Based on Employers' Needs

Since an employer adopting an Episode-based Benefit Plan will build on its current plan, each employer's approach to episodes of care will vary depending on the employer's current plan offerings. For example, a high-deductible health plan is constrained in the types of cost-sharing relief that an employer may offer. And every plan differs from the next in the actuarial value and amount of cost-sharing required from its enrollees.

The three-tiered cost-sharing approach is designed to help employers adapt an Episode-based Benefit Plan with various cost-sharing and plan design "dials" such as the types of cost sharing, the amounts of cost sharing and the use of extra incentives. All of these are tools that an employer can adjust to achieve the plan's goals while maintaining actuarial equivalence with the plans the employer offered in the past.

The actuarial value of a plan describes the percentage of total covered health care costs paid for by the plan, as opposed to the percentage paid by the enrollee through cost-sharing. For example, a plan with a 70% actuarial value would be expected to cover 70% of the plan's health care costs over a year, with enrollees paying the remaining 30% through cost-sharing. This is just an estimate and will vary depending on actual utilization. Many of strategies in this paper for designing an Episode-based Benefit Plan, such as offering low cost sharing to enrollees for using high-value providers for high-value episodes, may increase the actuarial

value of the plan if not offset by other changes, such as increasing cost sharing for low-value episodes. The available dials and levers are designed to help employers arrive at the right balance of cost and benefits for their employees.

Employers should take care to keep the actuarial value of the plan over a minimum 60% threshold so as not to potentially incur tax penalties. The Affordable Care Act imposes a requirement on large employers to offer health coverage that is affordable and that provides minimum value to at least 95% of their full-time employees and their dependents or otherwise potentially be subject to an employer shared responsibility payment.[13] Coverage is considered to provide minimum value if the plan (1) pays at least 60% of the cost of benefits and (2) includes "substantial coverage of inpatient hospital services and physician services."[14] Federal regulators have not defined "substantial coverage."[15]

Employers should take care to keep the actuarial value of the plan over a minimum 60% threshold so as not to potentially incur tax penalties.

Implementing the Episode-based Benefit Plan – Operational Considerations

When Episodes Begin

Offering special cost sharing for in-episode care requires an explicit definition of when an episode begins. Fortunately, episodes are designed with these definitions explicitly stated, and they typically begin (or are "initiated") on receipt of a qualifying claim.[16] Plans may want to establish processes by which EOC contracted providers give more prompt notice to the plan's administrator of an episode initiation, so that the plan can begin communication and support for the enrollee. Episodes will typically have a "look back" period, encompassing care that occurred in the days prior to the episode-initiating event.

Enrollee Transparency & Support

The success of an Episode-based Benefit Plan depends on individual enrollees making smart decisions about their care in the context of their new plan design. This means employers must offer transparency and guidance at every stage of the enrollee's experience. There are several steps an employer might take to make sure that enrollees remain informed about episodes and their unique cost-sharing.

At launch, employers should publicize the Episode-based Benefit Plan through plan documents, enrollee information sessions and other open enrollment materials. Employers might also consider using health advocates to explain advantages and potential savings for enrollees. For example, the state of Connecticut's episodes of care "Network of Distinction" program was highly publicized by the state in public and employee-facing channels.

As the plan year progresses, employers must make educational materials available to enrollees so they understand how much episodes might cost and how they can save by selecting providers who are contracted at or below the episode price. Network tools and directories must also be structured to easily allow enrollees to search for providers who have contracted on an episodic basis. And enrollees should have easy online references to search for and shop episodes. Connecticut's Health Advocate program provides a ready example of a consumer-friendly shopping service that supports episodes of care.[17]

- At launch, employers should publicize the Episode-based Benefit Plan through plan documents, enrollee information sessions and other open enrollment materials.
- Employers should consider using health advocates to explain advantages and potential savings for enrollees.
- Employers should make educational materials available to enrollees so they understand how much episodes might cost and how they can save by selecting providers who are contracted at or below the episode price.
- Plans should empower providers with this same information so they can help guide enrollees into the advantageous cost sharing available for episodes of care.

These principles are aligned with recent regulations imposed on health plans to ensure cost transparency.[18] As part of the new health plan transparency rules, beginning in 2023, plans will be required to make available, among other information, an enrollee-specific estimate of the cost of a particular service at a particular provider along with a cost-sharing estimate. The rules include specific provisions for bundled payment arrangements; for example, when an enrollee requests information for an item or service subject to a bundled payment arrangement, the plan must provide a list of the items and services included in the bundled payment arrangement for which cost-sharing information is being disclosed. Plans can design their tools to satisfy simultaneously the operational need for full disclosure of episode pricing and the regulatory need to meet the requirements of the transparency regulation.

Finally, enrollees are not the only ones who need access to information and tools. Plans should empower providers with this same information so they can help guide enrollees into the advantageous cost sharing available for episodes of care.

Prescription Drugs

Prescription drug pricing is both an affordability issue and a source of confusion for employers and enrollees alike. Episode payments can help address these concerns by bundling the costs of prescription drugs within the fixed price paid to the EOC contracted providers. In that case, the combined episode cost covers both medical services and prescription drugs.

The cost of drugs within an episode, for both enrollee cost sharing and provider payment purposes, should be pegged to the point-of-sale cost of a drug, rather than the net cost of a drug after all year-end rebates. This will avoid the need for cumbersome year-end recalculation processes, and allow providers and enrollee to make cost-informed decisions based on the same pricing information.

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Plan sponsors may need to ensure their TPAs and PBMs are aligned to make sure that pharmacy claims are processed correctly, even if some post-claim reconciliations are needed. In some cases, pharmacy claims processed at the point of sale are processed through plan systems before medical claims, meaning the pharmacy claim must be reprocessed after an episode is triggered.

Other Cost-Sharing Considerations

There are some special procedures and provisions a plan might want to adopt to smooth the implementation of and enrollee experience in the Episode-based Benefit Plan.

For chronic care episodes, which might include all related care over a calendar-year period, the plan can minimize the out-of-pocket burden imposed on the enrollee by dividing the obligation into quarterly or monthly payments rather than imposing all cost sharing at the beginning of the year. For procedural episodes, which are shorter term but still can stretch over a period of a few months, plans should ensure that care episodes paid for near the end of the year, and the associated cost sharing, will be covered under that episode even as a new plan year begins, to avoid double charges.

Coordination of Benefits (COB)

Under current coordination of benefit rules and principles, plans will have difficulty implementing an episode-based pricing structure and an episode-based cost-sharing program when the plan is secondary to another payer, given the difficulty of calculating the applicable cost sharing. It may be less complicated to carve out secondary payer situations from episode-based care and treat these cases under the plan's baseline, non-episode benefit.

It may be prudent to carve out secondary payer situations from the Episode-based Benefit Plan and treat these cases under the plan's baseline, non-episode benefit.

Implementing the Episode-based Benefit Plan – Regulatory Considerations

Many of the benefit features of the Episode-based Benefit Plan, other than its cost sharing, will be the same as those of the traditional "base" plan it is layered upon. In this way, the Episode-based Benefit Plan relies on the base plan's regulatorily compliant design. But there are a few regulatory considerations relevant to the episode payment feature itself, as discussed below.

Mental Health Parity

Like most other plans offered by employers, any Episode-based Benefit Plan must be designed to comply with the prevailing federal rules under the Mental Health Parity and Addiction Equity Act (MHPAEA).

Broadly speaking, that law prohibits group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less-favorable limitations on those benefits than on medical/surgical benefits. There is nothing inherent in the Episode-based Benefit Plan's design that violates these mental health parity principles. But given the complexity of any health plan design, it is important to be conscious of the rules and test compliance in advance to avoid any inadvertent missteps.

The limitations imposed by the MHPAEA on group health plans fall into two categories: quantitative treatment limits (QTLs) and non-quantitative treatment limits (NQTLs). On the QTL side, a plan that provides both medical/surgical and MH/SUD benefits may not apply any financial requirement or treatment limitation to MH/SUD benefits that is more restrictive than those imposed on medical/surgical benefits.[19] Plans must test in advance to ensure they are not applying any financial requirement or quantitative treatment limitation to MH/SUD benefits that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits.[20]

This test is mathematical, and the results of the test will depend on the particular implementation of the Episode-based Benefit Plan that the employer picks. In general, there are some factors that can assist an employer in developing a plan design that passes. For example, if a plan provides benefits through multiple tiers of in-network providers (such as preferred and non-preferred) with different levels of cost sharing, the plan may divide benefits into subclassifications that reflect these tiers for purposes of quantitative analysis. This suggests that plans may separately test the quantitative restrictions on in-episode and out-of-episode care. To do so, the tiering must be based on reasonable factors (akin to those discussed below for NQTLs) such as quality, performance and market standards, and without regard to whether the provider delivers medical/surgical benefits or MH services.[21] In cases where a plan does not meet the quantitative standards, the plan can implement one of many "fail-safe" mechanisms commonly used by plans today, such as capping cost sharing for specific mental health services.

The second area where the Act limits plans is in the design and application of NQTLs. These are the plan designs and strategies (other than financial and quantitative ones) that restrict the benefits afforded to enrollees. Examples include prior authorization and other utilization management practices. In designing these elements, plans may consider a wide variety of factors, including service type, geographic market,

demand of services, supply of providers, provider practice size, Medicare reimbursement rates, and training, expertise and licensure of providers. These factors must be applied comparably and no more stringently to behavioral health services than to medical/surgical services. Disparate end results alone do not mean an NQTL is out of compliance, but they are seen as red flags. Recent guidance made it clear that plans must be able to demonstrate that they follow comparable processes, strategies, evidentiary standards or other factors in determining rates for both medical/surgical and MH/SUD benefits.

New federal laws require heightened scrutiny of plans' NQTLs. Under the Consolidated Appropriations Act, 2021, group health plans subject to MHPAEA must proactively perform a parity analysis of NQTLs and, upon request, make the results of that analysis available to the U.S. Department of Labor (DOL). The law also requires the DOL to issue a new MHPAEA compliance guide, which will contain more examples of acceptable and unacceptable NQTLs. In subregulatory guidance, the DOL has already begun explaining the extensive analysis needed to comply, and the DOL will focus its regulatory efforts on such limitations as "Standards for provider admission to participate in a network, including reimbursement rates."[22]

Relevant to the design of the Episode-based Benefit Plan, the selection of providers for episode contracting and the selection of episodes themselves are likely a form of NQTL. When selecting providers for episodes or selecting episodes themselves, a plan should confirm that its provider selection processes for behavioral health services are comparable to and applied no more stringently than those for medical/surgical benefits. To do this, plans should adopt neutral policies that identify factors such as provider cost and quality, rather than service type, to guide decision-making. Sponsors should perform and document this analysis in accordance with the new requirements imposed under the Consolidated Appropriations Act, 2021.

Adequate Network of Episode-of-Care Contracted Providers

The selection of EOC contracted providers is an important process. A plan must have an adequate network of EOC contracted providers available so that enrollees can readily make their choice to obtain care from one.

The main reason to provide an adequate network of EOC contracted providers is to assure success of the Episode-based Benefit Plan and enrollees' satisfaction within it. If enrollees are incentivized to use EOC contracted providers but there are no providers to be seen or the providers close to the enrollee are unacceptable, the enrollee will face an unappealing choice: use a low-quality provider, travel a great distance to an acceptable episode-contracted provider or pay high out-of-pocket costs to a non-EOC contracted provider. All of these are liable to foment dissatisfaction with the Episode-based Benefit Plan and with the employer offering it.

There are also regulatory reasons a plan should ensure an adequate network of quality providers. While most state and federal laws that regulate network adequacy do not apply to self-funded group health plans, one that does is the federal maximum on out-of-pocket costs (MOOP) in a non-grandfathered group health plan. Non-grandfathered group health plans are required to set MOOPs at an annual limit determined by federal regulators.[23]

Plans are required to establish their MOOP only for Essential Health Benefits (EHB). Plans are not required to apply a MOOP to benefits that are not EHB. To determine which benefits are EHB for purposes of complying with Public Health Service (PHS) Act Section 2707, the federal government considers self-insured group

health plans to have used a permissible definition of EHB if the definition is selected from among one of the many state EHB benchmarks authorized by the Secretary of HHS (10 per state), from any state.[24] Plans may limit the costs that accrue toward the MOOP so as to exclude out-of-pocket spending for out-of-network items and services.[25]

In the Episode-based Benefit Plan design, cost sharing in Tiers 1 and 2 are counted toward the MOOP. But cost sharing paid to non-EOC contracted providers in Tier 3 is not. The Department of Labor requires that if a group health plan uses a reference-based pricing structure, treats providers who accept the reference-based price as the only in-network providers, and wants to exclude cost sharing from the annual limit on cost sharing on claims from providers who do not accept the reference price, the plan must use "a reasonable method to ensure that it provides adequate access" to quality providers who accept the reference price.[26] This means that a plan using episode-based pricing and not counting costs of non-episode providers toward the out-of-pocket maximum should find a "reasonable method" to measure adequate access. The DOL has specified that a reasonable method would:

- Apply reference pricing only to services for which the period between identification of a need for care and provision of the care is long enough for the patient to make an informed choice.
- Not apply reference pricing (or count amounts in excess toward the MOOP) for emergency services.
- Have procedures in place to measure whether an adequate number of providers accept the reference price. Plans may use state-generated access measures or geographic distance and wait-time measures.
- Include procedures to ensure that an adequate number of providers meet the quality standards.
- Include an exception process for situations in which there is no access to a provider who accepts the reference price or there is no access to a quality provider.
- Include specific disclosures automatically through the plan's documents and upon request.

In areas where networks may be inadequate, an employer might consider not offering the Episode-based Benefit Plan, focusing its efforts at first on the states or metro areas where there are a sufficient number of providers.

It is also important that a plan select providers based in part on predetermined standards of quality and price. Having these standards in place will help demonstrate a fair selection process to enrollee and provider alike. These standards are also important for meeting the non-quantitative standards of federal mental health parity law, discussed above.

Surprise Billing

Implementing an Episode-based Benefit Plan can help limit the impact of surprise bills for enrollees and is consistent with federal legislation and proposed regulations addressing this issue.

When an enrollee obtains care with an EOC contracted provider, the enrollee's cost sharing is fixed regardless of the actual cost of care. This means that excess costs of all stripes are borne by the provider and plan together, rather than by the enrollee. This approach meets both the spirit and the letter of surprise billing laws, which are designed to protect enrollees from certain out-of-network bills. When an out-of-network

provider submits a bill for care associated with an episode, that bill is allocated between the plan and provider, not to the enrollee. The enrollee's cost sharing remains the same percentage of the fixed episode price that it would have been had the enrollee seen an in-network provider. There is no "surprise" to be mitigated, and no need for the enrollee to be protected from the out-of-network provider's billing practices.

Gatekeeper & Referral Requirements

The Episode-based Benefit Plan does not need an HMO-style gatekeeper or referral requirement. The principles of the plan require enrollees to make conscious decisions about their care and its costs, and episodes are triggered automatically based on claims or other triggers. Primary care providers and others can help promote use of EOC contracted providers without gatekeeper authority, which could be an unnecessary burden in some cases.

Plans may want to retain prior authorization requirements for certain services to serve as a notification that an episode has been triggered. But once an episode is initiated, the providers managing the care could be given more leeway to determine the clinically appropriate and cost-effective course of treatment, without needing plan approval.

Covered Services

The Episode-based Benefit Plan does not require any changes to the actual services that the plan covers. An employer adopting an Episode-based Benefit Plan can generally rely on its existing slate of covered services, while changing only the cost sharing that applies to those services when inside or outside an episode.

One feature that an employer could consider is allowing EOC contracted providers to offer additional services "in lieu of" those covered under the plan if they believe it will improve the cost and quality of care provided in the episode. For example, an episode-of-care provider might offer additional days of home health care beyond those covered by the plan to prevent readmissions or to shorten stays in a post-acute facility. Plan documents should make clear that these are not services under the benefit plan, but instead are services offered by the providers themselves at no additional cost to the enrollee.

Appeals & Exceptions

Plans can rely on their existing grievance and appeals processes to adjudicate any disputes with enrollees (and providers) over matters concerning the Episode-based Benefit Plan. However, the types of disputes that arise may involve novel questions and arguments, and a plan and its administrator should be prepared to address them. For example, enrollees may question whether a particular service should be included in an episode or whether they meet the clinical and claims criteria to be covered by an episode at all. This highlights the need to inform the plan's administrators about the Episode-based Benefit Plan and to prepare appeals adjudicators for these types of disputes.

It will be important to inform the plan's administrators about the Episode-based Benefit Plan and preparing appeals adjudicators for new types of disputes pertaining to the Episodes of Care Plan.

Wellness Programs & Incentives

Many employers have established wellness programs for their employees. These typically offer rewards for completing a health-related activity or a health objective. The Episode-based Benefit Plan does not require a wellness program to accompany it. Yet employers might want to offer incentives to bolster employee participation in the Episode-based Benefit Plan, for example for selecting EOC contracted providers and remaining with them throughout the episode. Employers should be aware of the tax and design regulations relating to incentives when implementing such a program.

Employers might also retain their existing wellness program as a feature of the overall Episode-based Benefit Plan implementation. Employers keeping their existing wellness program should consider whether the total amount of incentives offered through the wellness program, when combined with any incentives offered through the Episode-based Benefit Plan, is within the permissible limits for incentives. Regulations typically require that incentives in some types of wellness programs be limited to no more than 30% of the total cost of coverage (or 50% for tobacco cessation).

Employers keeping their existing wellness program should be sure to consider whether the total amount of incentives offered through the wellness program, when combined with any incentives offered through the Episode-based Benefit Plan, is within the permissible limits for incentives.

Health Factor Discrimination

Group health plans are prohibited from establishing any rule for eligibility of benefits "that discriminates based on any health factor that relates to that individual or a dependent of that individual."[27] Despite this seemingly broad prohibition, there are a number of exceptions and limitations that a plan sponsor can rely on in designing and implementing the Episode-based Benefit Plan.

Notably, the nondiscrimination rules interpreting this prohibition were not written to require that all individuals receive the same coverage regardless of their medical condition. They were written to prevent discrimination **against** individuals based on a health factor. There is a broad exception to the nondiscrimination rules allowing "benign discrimination."[28] According to federal regulations, the nondiscrimination principle does not prevent a plan from establishing more favorable rules for an individual who has an adverse health factor than for someone who does not, with respect to "eligibility," which includes eligibility for "[b]enefits (including rules relating to covered benefits, benefit restrictions, and cost-sharing mechanisms such as coinsurance, copayments, and deductibles)."[29]

Moreover, a safe harbor allows that "a plan amendment applicable to all individuals in one or more groups of similarly situated individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at any individual participants or beneficiaries."[30]

Applying these principles, sponsors adopting the Episode-based Benefit Plan should do so only at the beginning of a plan year, and not midyear, to avail themselves of the safe harbor regarding benefits directed at individual participants. Sponsors should be able to design a plan that "benignly discriminates" in favor of enrollees with adverse health factors. Incentives for enrollees within the Episode-based Benefit Plan should either be designed in accordance with the applicable rules for wellness programs or be reviewed for compliance with the requirement that they apply uniformly and are not directed at specific individuals. In particular, if an episode of care structure is adopted for a particular condition, it should be applied to all similarly situated individuals in the plan. This does not preclude a plan design that sets unique cost sharing for particular services, though the plan could not alter the otherwise applicable cost sharing merely because someone had a particular diagnosis.

Sponsors adopting the Episode-based Benefit Plan should do so only at the beginning of a plan year, and not midyear, to avail themselves of the safe harbor regarding benefits directed at individual participants.

Incentives for enrollees within the Episode-based Benefit Plan should either be designed in accordance with the applicable rules for wellness plans or be reviewed for compliance with the requirement that they apply uniformly and are not directed at specific individuals.

Preventive Services

Federal law requires non-grandfathered group health plans to provide benefits for and prohibit the imposition of cost-sharing requirements with respect to certain preventive services.[31] To ensure that plans will actually have sufficient network capacity to deliver free preventive health services, the federal government requires that if a plan does not have in its network a provider who can provide a preventive service, the plan must cover the service at an out-of-network provider and may not impose cost sharing.[32]

If an episode of care includes preventive services, the plan should include a sufficient number of providers in the preferred tier who can perform preventive services at no cost sharing within the single payment. Otherwise, it should allow enrollees to obtain these services at non-preferred providers at the same cost-sharing rate. Plans may also create special rules for $0 cost sharing for preventive services even when included in an episode.

Conclusion

The Episode-based Benefit Plan is an innovative framework for health plans to maximize the cost-saving and quality-improving potential of episode-based payments. In the Episode-based Benefit Plan, employers, providers and enrollees share aligned incentives through thoughtfully designed plan cost that motivates enrollees to use EOC contracted providers. In such a plan, enrollees who receive care included in an episode can be offered a tiered cost-sharing structure, with coinsurance percentages increasing with costs. Those who select EOC contracted providers will benefit from predictability of costs, and, if they select lower-cost EOC contracted providers, the most advantageous cost-sharing rates. Those who do not make such selections face unpredictable fee-for-service costs, and potentially higher cost sharing. Employers must design and implement their program carefully, with attention paid to enrollee education, transparency of information and regulatory compliance. And those who do may find this framework can motivate enrollees to select the providers and services that most benefit themselves, while helping their provider improve their care, and their plan lower costs.

[1] NIHCM Foundation (see https://nihcm.org/publications/the-burden-of-rising-health-spending).

[2] RAND HIE (see https://www.rand.org/pubs/research_briefs/RB9174.html).

[3] 2020 Health Care Delivery Survey, Willis Towers Watson (see https://www.willistowerswatson.com/en-US/Insights/2020/10/2020-health-care-delivery-survey).

[4] Lewin Group report on CJR (see https://innovation.cms.gov/data-and-reports/2020/cjr-thirdannrpt (p. 4).

[5] Brooks-LaSure et al. (2021) (see https://www.healthaffairs.org/do/10.1377/hblog20210812.211558/full/).

[6] Cole et al. (2020) (see https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2767589.

[7] Barankay et al. (2020) (see https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2771525?resultClick=3).

[8] Wong et al. (2017) (see https://jamanetwork.com/journals/jamapediatrics/fullarticle/2657311).

[9] Asch et al. (2015) (see https://jamanetwork.com/journals/jama/fullarticle/2468891).

[10] See https://vbidhealth.com/wp-content/uploads/2021/09/Employer-Whitepaper-092021.pdf.

[11] "Clinically Driven Payment and Benefit Design to Improve Health Equity: The Case of Obesity Prevention and Treatment," Health Affairs Blog, September 9, 2021.

[12] Michigan VBID Center (see https://vbidcenter.org/initiatives/low-value-care/).

[13] 26 U.S.C. § 4980H; 26 C.F.R. § 54.4980H-4(b)(1).

[14] 45 C.F.R. § 156.145(a); proposed 26 C.F.R. § 1.36B-6. 78 Fed. Reg. 25950 (May 3, 2013). The regulations on minimum value are still in their proposed form, but the IRS has indicated that employers may rely on them. (See https://www.irs.gov/affordable-care-act/employers/minimum-value-and-affordability.) This paper treats these regulations as final for purposes of discussion.

[15] 80 Fed. Reg. 10828, 10872 (Feb. 27, 2015). A nonstandard plan may need to rely on the certification of a qualified actuary to determine that the plan covers the required 60% of the cost of benefits; to complete that certification, the actuary will analyze the plan's standard features using the calculator and then perform an additional calculation to measure the anticipated value of the plan's nonstandard features. Proposed 26 C.F.R. § 1.36B-6(d).

[16] For an example of episode definitions, visit the Care Innovation Institute at https://www.careinnovationinstitute.com/. Or see the CMS methodology for describing episodes in the BPCI advanced model test at https://innovation.cms.gov/innovation-models/bpci-advanced/participant-resources.

[17] Healthcare Advocate (see https://members.healthadvocate.com/Home).

[18] 29 C.F.R. § 2590.715-2715A2.

[19] 29 C.F.R. § 2590.712(c)(2).

[20] 29 C.F.R. § 2590.712(c)(2).

[21] 29 C.F.R. § 2590.712(c)(3)(iii)(B).

[22] DOL FAQ 45 (see https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf).

[23] PHS Act § 2707(b).

[24] ACA FAQ 18, Q2 (available here: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs18).

[25] ACA FAQ 18, Q4.

[26] DOL FAQ 31, Q7 (available here: https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-31.pdf). See also https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Reference_Pricing_FAQ_101014.pdf.

[27] 29 C.F.R. § 2590.702(b)(1)(i).

[28] 29 C.F.R. § 2590.702(g).

[29] 29 C.F.R. § 2590.702(b)(1), (g)(1)(i).

[30] 29 C.F.R. § 2590.702(b)(2)(i)(C).

[31] 42 U.S.C. § 300gg–13(c).

[32] 45 C.F.R. § 147.130(a)(3)(ii).

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