ENGELBERG CENTER for
Health Care Reform
at BROOKINGS

August 2011

DISCUSSION PAPER

Promoting High Quality and Value through Health Insurance Exchanges

Introduction

The Patient Protection and Affordable Care Act (ACA) was enacted to provide Americans with greater access to health insurance coverage, while improving health care quality and lowering overall health care costs. The establishment of state-based health insurance exchanges (Exchanges) is one of the main elements in the legislation to provide insurance coverage to more Americans. In early July 2011, the Department of Health and Human Services published a Notice of Proposed Rule-Making (NPRM) to provide detailed requirements for the implementation of Exchanges. However, guidance on how Exchanges should measure and report on health care quality is only addressed very broadly in the NPRM.

The Engelberg Center for Health Care Reform at Brookings convened a panel discussion[1] on June 25, 2011 to focus on how Exchanges can improve health care quality and value through better measurement, purchasing strategies, and providing consumers with compelling quality information to enable more informed health care decisions. The event was supported by the Robert Wood Johnson Foundation. Panelists from eight different states highlighted different stakeholder perspectives on how to improve quality through the Exchanges. Panelists drew upon their experiences to highlight examples of current best practices, promising approaches, and critical challenges in implementing effective quality measurement and reporting efforts. This brief discussion paper summarizes key issues and discussion themes from the event.

Notice of Proposed Rule-Making

Joel Ario, Director of Health Insurance Exchanges in the Department of Health and Human Services, opened the meeting by commenting on the importance of making compelling information about health quality and value easily accessible to consumers. He noted that such an approach has the benefit of providing necessary information to enable consumer decision-making and in turn will motivate health plans participating in the insurance exchanges to continuously improve their quality and value. Mr. Ario explained that the NRPM is intended to provide states with flexibility in implementing exchanges and offered that the Department of Health and Human Service (HHS) will continue to partner with states that are not able to implement an Exchange by January 1, 2014. HHS will maintain a federal exchange to support these states. Mr. Ario offered that core responsibilities of HHS will be to develop a health plan rating system, define the elements of the "quality improvement strategy" that will required of qualified health plans, and determine the level of flexibility states will have to innovate on top of federal "floor". HHS will provide information through additional rule-making on these issues.

Discussion Panel I: How can Health Insurance Exchanges Promote Quality through Measurement and Reporting?

The NPRM requires that the Exchanges, among other activities, "evaluate quality improvement strategies and oversee implementation of enrollee satisfaction surveys, assessment and ratings of health care quality and outcomes, information disclosures, and data reporting." Little additional guidance is offered in the NPRM on

[1] See Appendix for event agenda and a list of panelists

how Exchanges should perform these roles.

Health plan improvement is commonly measured today using an array of standardized performance measures. Standardized health plan measures used nationally today come from mainly three sources: the Healthcare Effectiveness Data and Information Set (HEDIS) performance measure set developed and maintained by the National Committee for Quality Assurance (NCQA), the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey developed by the Agency for Healthcare Research and Quality (AHRQ), and the Centers for Medicare and Medicaid Services (CMS).

These measures include preventive care and clinical process measures, select intermediate outcomes measures (e.g., blood pressure, cholesterol, or blood sugar control for health plan members with diabetes), as well as measures of care experience and outcomes (e.g., functional status) for different populations. These performance measures are specified, collected and calculated in a manner allowing for easy comparison of health plan performance.

Many purchasers require that health plans collect these measures. CMS also requires that health plans participating in the Medicare Advantage[2] program report these measures to beneficiaries and the public. In addition, many states require that Medicaid managed care programs report these measures; some states also mandate that private plans report these measures through state health departments or insurance commission requirements.

While many performance measures are available today, there are also a number of key opportunities for more robust measure development. For example, some critical measurement areas such as affordability or cost/efficiency, care coordination and transitions, health and functional status or other outcomes, and other important measurement areas are not included or are inadequately addressed. At the same time, some of these measurement areas are of great interest to consumers, physicians, employers, regulators, and others. In addition, while many programs and initiatives across the public and private sectors require or encourage the collection of performance measures, data collection requirements are not consistently aligned, resulting in the use of different measures for similar purposes, creating significant burden on health plans and providers.

Panelists raised a number of critical issues that would strengthen the opportunity for Exchanges to improve quality and value. All panelists stressed the important role that Exchanges can play in promoting greater quality improvement through measurement. To that end, building on available measures and metrics that health plans use to measure, report on, and improve performance was seen as critical. Panelists indicated particular interest in measures that focus on care experience (e.g., CAHPS), preventive and chronic care (e.g., HEDIS), and measures of care transitions (e.g., readmissions). These metrics should be harmonized and aligned not only for the implementation at the health plan level, but also with other measurement programs and requirements at both the provider and health plan level. Such measurement efforts might include statewide pay-for-performance programs or medical home initiatives targeting providers, or federal efforts such as CMS requirements for Medicare Advantage health plans as well as efforts targeting providers (e.g., meaningful use, Physician Quality Reporting Systems, etc.). For these efforts, states or Exchanges can serve as conveners and support stakeholders' efforts to harmonize metrics.

While many valuable measures are available today, critical gaps remain. In particular, panelists highlighted a need for measures in areas such as care coordination, cost, and appropriateness. Measure development must happen quickly so that meaningful, sound, well-tested, and feasible measures can be implemented quickly through Exchanges.

Finally, as states are moving forward with the incorporation of performance measurement results into Exchanges, best practices in the deployment and use of measures and their impact on cost, population health,

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[2] http://www.medicare.gov/navigation/medicare-basics/medicare-benefits/part-c.aspx

and health care quality should be systematically identified and shared. Creating effective feedback loops between states and HHS will allow for continuous learning about which measurement approaches yield desired results, so that effective practices can be disseminated quickly.

Discussion Panel II: Promoting Quality and Value through Purchasing and Other Strategies

The NPRM acknowledges that purchasing activities can be an important strategy to support improvement and HHS proposes to provide Exchanges with discretion and flexibility on specific approaches.

Purchasing strategies exist along a continuum. "Exchanges as a market organizer" are on one end of the continuum while "Exchanges as an active purchaser" are on the other end of the continuum. The *market organizer* (or "any-willing plan") approach promotes competition by offering comparative, streamlined information about participating health plans. It may offer decision support tools for consumers based on aspects such as cost sharing or quality performance, but it does not limit plan participation or benefit structure availability. Exchanges as *active purchasers* limit choice of plans based on performance and other criteria, set benefit packages, and negotiate premiums. In the active purchaser model, the exchange works much like a large private employer procuring benefits on behalf of its employees.

In the private sector, some large employers rely on quality measurement results and health plan comparison tools to encourage competition among plans and make purchasing decisions. For example, eValue8, a Request for Information tool developed by the National Business Coalition on Health (NBCH), is used by purchasing coalitions and others to help assess HMO, POS, and PPO plan performance in key service and programmatic areas. Purchasers may incorporate the quality and value information submitted by the health plans into their procurement decisions and vendor management.

In the public sector, existing insurance exchanges use a variety of purchasing strategies. The Utah Health Exchange acts as a market organizer, offering a variety of health plans for consumers and small businesses; in addition, it offers tools for viewing side-by-side health plan comparisons that can be filtered based on a variety of preferences.[3] In Massachusetts, the Health Connector acts as an active purchaser, using its authority to select participating plans to obtain premium discounts from carriers for individuals with premium subsidies.[4] It further assigns special designations to plans based on their cost and quality metrics to assist consumer decision-making, which may serve as an incentive for plans to offer better quality and value in order to become more attractive to consumers.[5]

Panelists stressed that states will need to evaluate their local marketplace to determine their own approach to purchasing. For example, some states may prohibit specific, active purchasing strategies. Additionally, gag clauses in current plan-provider contracts may not allow plans to publicly report on the provider performance.

Panelists stressed the opportunities that Exchanges have to align their purchasing strategies with others in the state, including other public sector efforts (e.g., Medicaid, public sector employee health care coverage purchasing) as well as purchasing efforts in the private sector (e.g., large employers, business collations, etc.). Such alignment is useful to send a consistent signal to health plans about performance expectations and to providers with respect to the importance of consistent measures. Moreover, such alignment is useful to small and large employers alike as it will increase their ability to rely on aligned measures in their health plan purchasing and selection decisions. Efforts to align should not come at the expense of plans' flexibility to implement benefit design or coverage options that may add value (i.e., provider tiering), or consumers'

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[3] "States in Action Utah Health Exchange" – February 2011, The Commonwealth Fund.
[4] Active Purchasing for Health Insurance Exchange: An Analysis of Options. From RWJF by Sabrina Corlette and JoAnn Volk, June 2011
[5] Schilling, Brian. "Purchasing High Performance Health Exchanges: Choice Without Hassle and the Heart of Reform." http://www.commonwealthfund.org/Content/Newsletters/Purchasing-High-Performance/2010/April-30-2010/Case-Studies/Health-Exchanges-Choice-Without-Hassle-and-the-Heart-of-Reform.aspx. May 2010.

opportunity to retain providers when changing plans whenever possible. Overall, panelists stressed that many individuals and small businesses have limited time to devote to comparing and selecting benefit packages, so Exchanges should focus on providing easy-to-compare information as simply and clearly as possible.

Exchange implementation will be most effective if health plans, consumers, employers, providers and others strive for solutions that take a “systems” view, rather than maximizing interests of specific stakeholders. One panelist described efforts to convert “stakeholders” to “shareholders” in order to convey a sense of ownership of the role of the Exchange in the state’s health care system.

Discussion Panel III: Engaging Consumers through Better Information

The NPRM requires that Exchanges implement a variety of consumer assistance tools, including an internet website that provides standardized comparative information on each available qualified health plan such as premium and cost-sharing information, results of an enrollee satisfaction survey, and quality ratings.

Through these and other avenues, Exchanges can provide compelling information that will enable consumers to select health plans that suit their needs. Current efforts can inform how Exchanges might consider providing compelling information to consumers.

For example, the Pacific Business Group on Health (PBGH) has established a “Health Plan Chooser” tool designed to simplify complex information—including information about cost, key plan features, and member ratings—to enable consumers to make apples-to-apples comparisons and focus on the plan features most important to them. A key feature of the tool is providing cost information tailored specifically to individuals’ and families’ anticipated medical needs.

In Massachusetts, the Health Connector displays ratings from a health plan report card compiled by the National Committee for Quality Assurance (NCQA) for each plan. Quality ratings incorporate HEDIS measure performance and rate plans from one to four stars in the domains of access and service, qualified providers, staying healthy, getting better, and living with illness. Exchange consumers can use these ratings, in combination with information about premiums, cost-sharing, and other elements of plan design, to make informed, quality and value-based purchasing decisions.

Consumers can only act as “smart shoppers” in an Exchange if they are provided with useful information about quality and cost. The discussion panel will focus on how to provide consumers with persuasive and easy-to-understand information.

Panelists commented on the need for exchanges to provide quality information both for health plans and providers to facilitate health plan and provider selection. It will be important to offer information via a variety of modes of access, including: web portals, written materials, and opportunities for telephonic and in-person interactions. Promising practices available today could inform each of these approaches.

Panelists agreed that Exchanges need to provide consumers with a simple, clear interface providing access to high-level, synthesized quality information with opportunities for consumers to drill down for more detailed information on benefit design, quality, cost, access, and provider networks, as well as the availability of potential value-added features such as tiered networks and the inclusion of “centers of excellence.” In addition, Exchanges should incorporate strong decision-making tools for consumers. These tools should provide information about several key issues, including cost (premium, out-of-pocket), quality, and participating providers. Consumers should also have the opportunity to input information that will enable their anticipated health costs to be incorporated into decision support.

Conclusion

Promoting health care quality through Exchanges is a critical yet underappreciated issue to improve health care. In concert and alignment with implementing other payment, access, and delivery reform efforts, implementing Exchanges are an important opportunity to jointly focus on a common, core set of improvement needs that can improve health care quality, lower cost trends, and improve the health of communities.

HHS is accepting commentary on the NPRM until September 28, 2011. It is anticipated that many of the issues raised during this panel discussion will be addressed in additional rules to issues as NPRMs soon or through additional rule-making.

APPENDIX I: MEETING AGENDA

Promoting Higher Quality and Value through Health Insurance Exchanges
Carnegie Endowment Conference Center
1779 Massachusetts Ave, NW, Washington, DC
Monday, July 25
8:30 am – 12:30 pm

Meeting Goals:
- Provide strategic input to potential quality measurement and reporting requirements in the NPRM for the Establishment of Exchanges released in early July 2011.
- Identify promising opportunities to support quality improvement promulgated through Health Insurance Exchanges as well as critical next steps to support effective implementation.
- Highlight perspectives from a diverse set of stakeholders.

8:00 Registration

8:30- 8:40 Welcome: Mark McClellan, Brookings

8:40 – 9:00 Opening keynote: Joel Ario, Director of Office of Health Insurance Exchanges at Department of Health and Human Services

9:00 – 10:00 How Can Health Insurance Exchanges Promote Quality Through Measurement and Reporting?

- What should a well-functioning system of quality measurement and reporting in Health Insurance Exchanges accomplish?
- What has been the experience about the usefulness of specific measurement domains, specific measures, etc. across the public and private sectors? What have been limitations; what are ripe opportunities for improved health care that could be advanced?
- How can these domains and measures be aligned with other public and private sector efforts focused on measuring and reporting on performance?
- What are measure gaps that need to be filled? Are there innovative measures that should be considered for incorporation by 2014? How can we get to better measures as quickly as possible?
- How can federal requirements support states in their efforts to promote quality/value?

Moderator: Joachim Roski
Panelists:
- Tricia Leddy, Executive Director, Office Health Policy and Reform, Rhode Island Department of Health
- Mike Russo, Policy Analyst, U.S. Public Interest Research Group
- Eduardo Sanchez, Vice President and Chief Medical Officer, Blue Cross and Blue Shield of Texas

10:00 – 11:00 Promoting Quality and Value through Purchasing and Other Strategies

- What effect do purchasing strategies—such as standard setting, selective contracting, benefit design standardization—implemented within an Exchange have on quality improvement?
- What are experiences and best practices from current public and private sector purchasing efforts that demonstrably improve quality or value?. What are the opportunities and risks in implementing such approaches?
- What other strategies are available to States through Exchanges to promote improvement (promoting plan choice and employer/consumer decision-making, alignment of approaches across state-based programs and initiatives, collaborative approaches to improving and measuring provider performance)? What has been the experience with such approaches to improve quality or value?
- How can quality measurement information collected for the HIE support provider-level measurement and quality improvement efforts?

Moderator: Mark McClellan
Panelists:

- Sabrina Corlette, Research Professor, Health Policy Institute, Georgetown University
- Helen Darling, President and CEO of the National Business Group on Health
- Allen Feezor, Senior Policy Advisor, North Carolina Department of Health and Human Services
- Lonny Reisman, Chief Medical Officer, Aetna
- Tammy Rostov, Owner, Rostov's Coffee and Tea

11:00 – 12:00 Engaging Consumers through Better Information

- What are promising practices from the public and private sector to make actionable, compelling information available and interactive?
- What are promising best practices to display/layer data to promote engagement and support decision-making through Exchanges?
- What type of cost and pricing information should be made available to consumers? How can/should such information be tied to information about quality?

Moderator: Mark McClellan
Panelists:

- Meg Gaines, Director, Center for Patient Partnerships, University of Wisconsin
- David White, President, MDI Imported Car Service, Inc.
- April Todd-Malmlov, State Health Economist - Health Insurance Exchange Director, Minnesota Departments of Commerce and Health
- Bill Kramer, Executive Director for National Health Policy, Pacific Business Group on Health

12:00-12:30 Summary, conclusions and wrap-up: Mark McClellan