Consumer-Purchaser
DISCLOSURE PROJECT
Better information. Better decisions. Better health.

Health Insurance Exchanges: Vision and Principles

The primary goal of the Health Insurance Exchanges is to organize access to insurance coverage for the millions of Americans who need affordable coverage. However, the development of these exchanges – both the federally-operated exchange and the individual state exchanges – provide a unique and critical opportunity to address the significant quality and affordability gaps that exist in today's health care delivery system. The Consumer-Purchaser Disclosure Project would like to see the federal government and the states recognize the potential for exchanges to serve as transformational tools, and design their exchanges in a way that drives improvements in quality of care, to further increase affordability across the entire system. To do so, exchanges must provide consumers with robust information on quality and cost of care, and they must include strong consumer and purchaser representation on governance bodies.

VISION

Exchanges activate consumers to make decisions based on quality and value. Many consumers are not aware of the variations in quality of care experienced in our current system, and the concept of quality does not intuitively link to the challenges and problems consumers face when navigating a fragmented health care system. Without this information, or understanding of the role they can play in helping to improve the system, consumers may rely simply on cost comparisons to make their health plan decisions. By providing clear information on the importance of quality to both the individual's care and to the system, exchanges can play a role in improving quality and reducing costs across the board. We hope that states will recognize the potential for exchanges to serve as transformational tools and design their exchanges accordingly.

Exchanges are designed to meet the needs of their beneficiaries: individual consumers, small employers, and their employees. For consumers, this includes providing useful information on quality, access, and affordability, as well as easy-to-use decision support tools. For small employers, this means providing a reasonable number of plan and product choices; offering premium aggregation, simplified billing and enrollment; and other business services to make participation as easy and attractive as possible. And in the future, for large employers this means establishing national standards and uniform processes for eligibility and enrollment, premium billing and payment, etc., to ease participation by multi-state employers.

Exchanges will promote the elements of a "healthy" marketplace, such as encouraging value-based competition among health plans and their affiliated providers. Ideally, plans will compete for enrollees by providing fully transparent information on plan and provider performance, as well as cost, using evidence-based, consumer-friendly quality metrics that support accountability. Other key roles for exchanges include using tools that have been proven by the purchaser community to drive improvements in overall value, such as surveys like eValue8 to assess health plan performance; engaging in selective contracting based on quality and value; seeking alignment with the purchasing strategies of large employers, Medicare and Medicaid; and, when necessary, having the authority to negotiate premiums.

Exchanges will continually monitor and ensure that Qualified Health Plans (QHPs) do not engage in activities that will result in adverse selection. For exchanges to grow and thrive as a viable market for individuals and employees to purchase coverage, they must develop compensatory mechanisms for addressing and mitigating the effects of adverse selection if it does occur.

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GOVERNANCE

Exchanges should be designed to serve consumers and their employers, and ultimately to ensure that consumers have access to high quality, affordable health insurance. The core role of the exchanges is to ensure that consumers have access to high quality, affordable health insurance. Thus, we believe that insurers and brokers ideally should not be permitted to serve on exchange governing boards. However, given the reality that states will want to include insurance representatives, it is essential that exchanges adopt policies 1) requiring complete, detailed accounting of potential conflicts of interest; and 2) prohibiting voting by those members who do have a conflict of interest.

Governing boards must include a majority representation by consumers, consumer advocates, and employers. Having a majority of consumers, consumer advocates and purchasers on the governance board can provide some assurance that insurers, providers, and other industry stakeholders – who have an inherent conflict of interest in this setting – do not threaten consumer and employer confidence in the exchanges. We recognize that in order to be productive contributors to such an entity, consumers, consumer advocates and purchasers may need assistance and support (e.g. mentorship, processes that facilitate their active participation, etc.). There are a number of states with experience in providing the type of support and education that may be needed, and HHS should look to those states for models.

FUNCTIONS OF AN EXCHANGE

Exchanges must establish a comprehensive set of metrics for identifying how well they are performing at the critical operations of assisting consumers and getting them into the correct program with any appropriate subsidies. The metrics collected to understand consumer experience should specifically target performance on the following: accuracy of eligibility and tax credit determinations; whether assistance (via call centers, the web portal, the Navigator program, or in-person) is being provided in an accurate, timely, effective, easy-to-access manner; evidence of bias in communications; and the effectiveness of the appeals process (both insurance coverage appeals and eligibility determination appeals).

Metrics should also be created to collect data on consumers' use of various "doorways" in order to track where consumers are primarily going for information. These data can be used to assess which of those doorways may require additional resources, as well as whether marketing and outreach efforts are achieving the goal of helping the exchange reach the right consumers.

QUALITY IMPROVEMENT INITIATIVES

In developing quality initiatives, it is critical that exchanges understand what information consumers want and need, and how they use this information. We urge that exchanges develop their quality initiatives closely in concert with the development of the web portal and other consumer assistance tools, to ensure that the quality measurement efforts will support and contribute to the use of this information by consumers.

We urge that exchanges be required to collect and report on a comprehensive set of consumer-tested measures on outcomes, processes tightly linked to outcomes, patient experience, patient safety and healthcare-acquired conditions; and volume (e.g., number of surgeries performed). The requirements should evolve, and the measure set should grow, as more measures that resonate with those who receive and pay for care become available (e.g., functional status, appropriateness of care, etc.).

Wherever possible, quality measures should be reported at the individual-physician level. Physicians may operate as part of a team, but patients and consumers are likely to make health plan choices based on the individual physicians in the QHP's network. Having individual physician-level information "fits" with the way many consumers make health care choices. Similarly, QHPs that include

patient-centered medical homes in their network should report on key outcomes – such as care coordination, chronic care clinical improvements, and patient experience – at the medical home level.

Measures of patient experience must be included in the comprehensive set of quality metrics required by QHPs. It is critical that exchanges require QHPs to publicly report patient experience data on the quality of care received across all settings, with tools such as the range of Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey instruments available at the health plan, clinician/group, and hospital levels, as well as the patient-centered medical home level when available. Evidence shows that having actionable data on patients' experiences of care leads to improved health outcomes.[1] Patient-reported and generated data in general are critical for improving overall quality of care, particularly for the highest cost, most complex patients, as well as patients generally.

Exchanges should be empowered to add additional measures based on local, regional, and private sector innovations in quality measurement. One example of a tool for assessing health plan quality that is widely used by private sector purchasers is the eValue8 tool, which provides evidence-based data on health plan quality in critical areas such as consumer engagement, disease management and health promotion, and behavioral health. Recognition of demographic and geographic differences in consumer needs and the nature of local delivery systems, as well as differences in experience with data collection across health plans and states, will strengthen the quality component of the exchanges.

CONSUMER ASSISTANCE TOOLS AND PROGRAMS

In all its consumer assistance activities, exchanges should enable consumers to make decisions based on quality and value. Combining information on cost with information about quality in a way that is easily understandable will allow consumers to make value-based decisions on their coverage. Providing quality information, linked to information on estimated costs, is particularly important for consumers with chronic conditions. The web portals should:

- Provide multiple approaches – and the appropriate decision-support tools – for consumers to navigate through the information according to their learning and usage style.
- Place information on quality and cost (value) up front and central, and develop tools that are intuitive and intelligent enough to provide alternative layers of decision support to meet the diversity of consumer needs and capabilities.
- Reflect consumer preferences, and allow consumers to screen plans by those that have their provider(s) in the QHP's network.
- Collaborate with regional public reporting efforts and employer-based efforts, to incorporate their experience and expertise regarding how to best communicate quality and cost to consumers, including assessing what consumers need to know to make the best decisions possible.
- Report the availability of QHPs' disease management programs; cost saving opportunities; patient coaching; shared decision-making programs; and prevention and care coordination initiatives, to assist decision-making by those who have multiple chronic conditions.
- Make available composite measures that reflect aspects of enrollee plan experience, such as claim denials, enrollment and disenrollment, complaints, and external appeals outcomes, with the option to drill down for more specific information if interested.

COST CALCULATOR

It is critical that the cost calculator fulfill the following two roles:

- ***Help consumers assess their out-of-pocket costs and subsidy amount***, given their expected income in the upcoming year, to allow them to avoid a situation in which they would be faced with having to refund a portion of the premium subsidy in the future.

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[1] M. Meterko, Ph.D., et al., "Mortality Among Patients with Acute Myocardial Infarction: The Influences of Patient-Centered Care and Evidence-Based Medicine," Health Services Research. 2010 Oct;45(5 Pt 1):1188-204.

- ***Provide a "cost at time of care" calculator that provides an estimate of all users' cost-sharing responsibilities***, based on the benefit design of each QHP. These cost sharing responsibilities should include annual cost of using care if the consumer's healthcare usage is average, high, or low; annual limit on costs excluding carve-outs, like dental coverage; the baseline deductible, as well as extra deductibles for hospital care, pharmaceuticals (both brand name and generic), and physician visits (primary care and specialty); and other coinsurance and out-of-pocket costs.

This information should be easily usable, viewable on the same page as summary information on quality and whether the individual's preferred providers participate in a plan's network, preferably in one easy-to-digest page. At the same time, consumers should be able to drill down and access more detailed information on cost, quality, flexibility, and coverage.

NAVIGATOR PROGRAM STANDARDS

Integral to the sustainability of the exchanges will be consumers' ability to decipher the potentially complex eligibility and enrollment processes. To best leverage the capacity of this effort, we suggest exchanges require the following of Navigator programs:

- Demonstrate experience with, and linkage to, resources that will enable them to educate consumers about choosing QHPs based on quality and value.
- Conduct detailed analysis of the service area to identify the populations with the highest need for assistance, and avoid awarding Navigator grants to entities that may not be skilled in reaching out to the needs of the community. This analysis should look for geographic concentrations of the target audience as well as other characteristic of the likely eligible population including race/ethnicity, language, age, income, etc. It should also examine the entity's track record of success reaching this or similar populations.
- Collect and report data on metrics that assess Navigator performance, and hold the programs accountable both during open enrollment, as well as throughout the year.
- Ensure that at least one of the types of entities serving as Navigators in each exchange be a community or consumer-focused non-profit.
- Institute strong conflict of interest policies. It is critical that Navigators be prohibited from serving as active health insurance agents/brokers in any health insurance market, and that they do not receive compensation from any health insurance issuers, inside or outside the exchange, during their term. Exchanges should monitor referral and enrollment patterns of all Navigators funded entities to ensure that conflicts of interest are not influencing Navigator activity.

SMALL BUSINESS HEALTH OPTIONS PROGRAM (SHOP) EXCHANGES

The success and sustainability of the SHOPs hinges on making them an easy and attractive tool for small employers to use. Within that context, we urge that SHOPs provide meaningful and reasonable choices, without including what may be viewed as an overwhelming array of choices that could have the adverse effect of making it more difficult for participants to decipher what would be the most appropriate QHP for themselves and their families. SHOPs should also provide cost calculators for both employers and employees, using the same "cost calculator" categories described above.

HHS should establish metrics to assess and hold SHOPs accountable for their functionality in providing small employers with the services they need in order to feasibly utilize the exchange, such as premium aggregation and other administrative simplifications to make participation as easy and attractive as possible.

CERTIFICATION STANDARDS FOR QHPS

Meaningful criteria and requirements must be in place for making Qualified Health Plan determinations. These requirements should include innovative practices regarding payment and benefit design, policies to guard against adverse selection, and network adequacy standards, such as the following:

- Enact a quality improvement strategy that provides incentives for providers to implement patient-centered care initiatives. These should focus on improving health outcomes, preventing readmissions, improving care coordination, advancing patient safety, reducing medical errors, and reducing disparities in care.
- Use innovative strategies and benefit designs to provide incentives to members that encourage the use of services and programs that improve their health. Health plans should use patient-centered tools designed to discourage the use of expensive services that do not add value, when good alternatives exist. These tools can include shared decision-making materials, as well as strategies such as tiered networks that provide members with incentives to use providers based on their quality and cost ratings.
- Make a commitment to promoting primary and integrated care. Insurers can demonstrate this commitment by paying more for primary care, increasing access to primary care services, and adopting strategies that pave the way for transformation from a fragmented, fee-for-service-based system, to a coordinated, patient-centered, value-based delivery system.
- Demonstrate continuous commitment to promoting efficiencies that will stabilize premium growth rates. Plans competing to enter into and remain in the exchanges must develop tools to avoid using premium increases as a way to make up for inefficient operations.
- Establish policies to avoid adverse selection into and within the exchanges, to ensure long-term sustainability. Plans must provide assurances and demonstrate the presence of policies to eliminate cherry-picking/adverse selection, and ensure that access is available to all consumers regardless of perceived risk.
- Be accredited by a nationally-recognized organization. QHPs must be recognized by accreditation programs; where appropriate, documentation and measures that are used as part of the accreditation process may be able to satisfy other qualification requirements (e.g. network adequacy, marketing materials, etc.) which would help states leverage scarce resources.

Network Adequacy Standards

It is critical that QHPs have provider networks that can accommodate the needs of the patient population and geographic regions they serve. Networks should be large enough to provide access to treatments and specialists for consumers living with multiple chronic conditions. QHP certification should also be an option for health plans that may have smaller networks, but are competitive when it comes to quality and value and can ensure access for all enrollees. While tighter provider networks could signal a health plan's intention to select only the healthiest enrollees, there are plans – such as those built upon a patient-centered medical home framework – that may not have a broad provider network but can still provide the type of coordinated, high quality, high value care that consumers and purchasers seek. Participation by smaller health plans that can demonstrate adequately-sized networks will be critical to reaching consumers in geographic regions where larger plans do not operate. The bar should be set appropriately to ensure that the largest players do not dominate at the expense of innovative, smaller plans.

States, Exchanges, and health insurance issuers should broadly define the types of providers that furnish primary care services. Given the millions of Americans who will be entering the health care system, it will be critical that non-physician providers be fully enabled to "practice up" to their level of training. For example, nurse practitioners are entirely capable of providing a wide range of care as part of a care team, should be allowed to work to the highest level of their license, and should be reflected in the QHP network.

Exchanges must collect data on a measure of QHPs' "network adequacy." This measure should be publicly reported to consumers, given the growing trend toward tighter networks, which may have significant effects on consumers' choice and access to care. The measure must be designed in a way that holds QHPs accountable for providing "real time" and accurate information on providers in their networks, which providers are accepting new patients, which provide comparative quality information to the plan or other entities, and which use electronic health records. This information is essential to consumers trying to choose providers.

QHP Issuer Participation Standards

QHP issuers must not implement benefit designs that have the effect of discouraging enrollment in a particular plan. Value-based benefit design (VBBD) should not be used as a smoke screen for methods of promoting adverse selection. VBBD must be implemented in a way that promotes quality, rather than promoting risk-based adverse selection. For example, QHPs with large provider networks should use quality-based metrics to signal to consumers which providers are offering the highest quality care. While large networks are reassuring for consumers who want to have a broad choice of providers, health plans should use strategies concerned with access, health plans should use strategies – such as quality and cost-based tiering – to signal to consumers which providers are most likely to provide the highest value care.

Standardization of benefits within the "metal" tiers (bronze, silver and gold) should be standardized to facilitate consumers being able to make "apples-to-apples" comparisons. Evidence indicates that having too many choices leads to confusion among consumers, who then may default to making choices based on cost or reputation rather than on overall value. Standardized benefits will also minimize risk selection via "creative" benefit design that could significantly cut off access to the most vulnerable consumers and potentially lead to adverse selection.

Accreditation of QHP Issuers

Bodies that are recognized by HHS as QHP accreditors must require plans to report performance on a number of quality and patient experience measures, using tools such as the HEDIS and/or CAHPS surveys. The accreditation process must include public reporting of accreditation and quality reporting results; a review of health plan processes related to marketing practices, appeals processes, utilization management, quality improvement, patient information programs, member privacy, and language access services; and maintain network adequacy standards that are at least equivalent to the NAIC's Managed Care Plan Network Adequacy Model Act.