Consumer-Purchaser
DISCLOSURE
PROJECT Improving Health Care Quality through Public Reporting of Performance

October 4, 2010

The Honorable Kathleen Sebelius
Secretary, U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Mr. Jay Angoff
Director, Office of Consumer Information and Oversight
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

File Code: OCIIO-9989-NC

RE: **Planning and Establishment of State-Level Exchanges; Request for Comments Regarding Exchange-Related Provisions in Title I of the Patient Protection and Affordable Care Act**
Comments from National Consumer, Labor, and Employer Organizations

Dear Ms. Sebelius and Mr. Angoff,

On behalf of the Consumer-Purchaser Disclosure Project, a collaboration of over 50 leading national and local employer, consumer, and labor organizations, we appreciate the opportunity to provide input on the Office of Consumer Information and Insurance Oversight's request for comments on federal and state health insurance Exchanges. The Disclosure Project is an initiative aimed at improving health care quality and affordability by advancing public reporting of provider performance information so it can be used for improvement, consumer choice, and as part of payment reform.

With 29 million individuals expected to secure coverage through Exchanges by 2019, Exchanges will have the leverage to transform how care is delivered in the marketplace, including employer-sponsored insurance. To facilitate this evolution, Exchanges must be active purchasers working with and on the behalf of consumers and employers to demand greater quality and affordability of care. We believe that the qualifying standards, minimum criteria, and broad authorities set out in the Affordable Care Act are a clear sign that Congress intended for Exchanges to be more than just a clearinghouse for plans. Congress recognized that individuals and small businesses, by themselves, lack the market clout to negotiate for high-value health plans and encourage insurers to invest in system changes to promote longer-term quality and affordability.

Exchanges must also function as disseminators of the innovative delivery system and payment reforms that the Affordable Care Act requires the federal sector to implement to lower costs. These include, but are not limited to, the National Health Care Quality Strategy and Plan that the Secretary must promulgate in 2011, and the reforms developed by the Center for Medicare and Medicaid Innovation and the AHRQ Center for Quality Improvement and Patient Safety. Exchanges can and should speed the adoption of vitally important reforms in the private sector.

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Specifically, we recommend that Exchanges, as active purchasers:

- Raise expectations for Exchanges and qualified health plans over time
- Set a high bar for the health plan rating system
- Provide consumers and purchasers with the information and tools they need to make value-based decisions about their coverage and their selection of providers
- Achieve immediate and long-term cost containment by incorporating the Affordable Care Act's value-oriented system changes for Medicare and Medicaid, sharing savings from increased coverage, and health plan product design
- Encourage a strong foundation for primary care and care coordination
- Encourage the reduction of disparities
- Customize information to meet the needs of individual consumers
- Balance the need for standardization to facilitate comparability across health plan products with the need for innovation

To support the success of Exchanges, the federal government and states must concurrently implement parallel requirements in the rest of the private market. If standards in Exchanges are higher than those in the rest of the private market, insurers as well as providers will have a reduced incentive to participate in Exchanges, minimizing the positive impact that they can have on the delivery system. Exchanges need an environment where they can flourish. This will also require the federal government and states to address growing concerns around health plan and provider consolidation that may stifle healthy competition the basis of value.

Raise expectations for Exchanges and qualified health plans over time (Questions C.5., D.2.a., E.1., E.2., J.1., J.2.)

As the federal government and states gain greater experience with Exchanges, the minimum thresholds for Exchanges and qualified health plans should not be static but should evolve to more effectively confront the quality and cost challenges that Americans face. Standards must also be updated on a regular basis to keep pace with advances in measurement, consumer education, medical science, and payment. As Exchanges develop successful practices, these should be used to inform minimum thresholds.

Set a high bar for the health plan rating system (Question E.1.)

The Affordable Care Act directs HHS to develop a ratings system to be used by Exchanges to rate plans on relative price and quality. In this comment letter, we delineate a number of expectations for qualified health plans. These expectations, as well as elements from eValue8, should be integrated into the rating system as appropriate. eValue8 is a tool that has been used by purchasers for about a decade to assess and manage the quality of their health plans. It assesses health plans on a variety of dimensions (e.g., plan support for members with limited English proficiency, member access to a personal health record, treatment option decision support).

Provide consumers and purchasers with the information and tools they need to make value-based decisions about their coverage and their selection of providers (Questions C.5., D.2.a., E.1.a., E.2., J.1.)

To make value-based decisions about their coverage, consumers and purchasers need comparative information on the quality and cost of care of each coverage option and its affiliated providers. The information must be founded on metrics that are meaningful to consumers and presented in a way that is understandable and actionable. We provide recommendations below on how Exchanges can best achieve these objectives and equip consumers to be effective buyers of value. Beyond facilitating consumer decision-making, publicly reporting this information can foster quality improvement, encourage health plans and providers to compete on the basis of quality and efficiency, and give employers information on how Exchanges are meeting the needs of their employees.

Make information on the quality of health plans and the individual providers operating within their network available to consumers and purchasers

Exchanges need to supply consumers with information on the quality of each health plan's products and the individual physicians and hospitals operating within their networks whenever feasible. Information at the individual provider level is an important part of coverage decisions. Consumers often want to select a plan that has their current physician(s) in the network. Exchanges should allow consumers the option of seeing how their physician(s) compares to others available in that plan's network. Consumers also need to know that there are individual physicians within the network who provide high quality care, reflect their values and preferences (e.g., the doctor is a good communicator, speaks primary language, provides after hours assistance), and can be trusted to help them make the best care decisions possible. Hospital-specific data, for example, can support a consumer who is contemplating surgery and wants to know the frequency of health care acquired conditions and infections at each hospital under consideration in the health plan's network. By making quality information on individual providers available through publicly accessible websites, Exchanges will also support patients' decisions about providers outside of the context of initial plan enrollment. Purchasers, with this quality information, will also gain insight about the level of care provided by qualified health plans.

Exchanges should publicly report plan and provider quality on a core set of measures. For health plan products, this information should at a minimum include accreditation status and performance on the Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS). HEDIS and CAHPS are national standardized tools used to, respectively, measure performance on important dimensions of care and service, and assess patients' experiences of care. In the case of individual providers, the set of measures should initially consist of patient experience, health outcomes (e.g., mortality, complications, and readmissions), processes with strong links to outcomes, and volume (e.g., number of surgeries performed). This list of provider measures should be quickly expanded to include additional measures that resonate with consumers as they become available (e.g., measures of pre- and post-treatment functional status, appropriateness of care, etc.). Exchanges may also consider incorporating information on whether a physician is participating in a Maintenance of Certification (MOC) program. MOC programs require physician participation in lifelong learning and continuous professional development and include, among other things, assessment of physician practice performance that includes patient experience and improvement.

Although information on individual physician performance is not widely available at this time, Exchanges can help fill this gap. For example, Exchanges can foster the availability of information on physician performance by encouraging qualified health plans to submit their health care claims data to a regional all-payer database, if one is available. Notably, Exchanges should require health plans and physicians to collaborate to accelerate the collection of patient experience data. Besides resonating with consumers, measures of patient experience can drive improvements in quality and cost of care because they are comprehensive indicators of the quality of care, particularly for the most high-cost, complex patients. Information on patient experience should also be a component of the enrollee satisfaction survey that HHS is required to develop to assess qualified health plans.

To avoid consumer information overload, Exchanges can use strategies such as composite scores that simplify the information for consumer presentation but also allow interested consumers to drill down to more granular performance data.

Allow consumers to calculate their predicted costs of coverage and care

Costs are a major consideration for most people when choosing a health plan. Exchanges need to help consumers predict their total costs of coverage, including both premium and out-of-pocket costs. Understanding out-of-pocket costs can be particularly challenging for consumers as they can differ tremendously across plan products. Exchanges should provide a simple out-of-pocket cost calculator that allows consumers to predict their costs based on their own likely needs, the plan's coverage and its contracted rates with providers (e.g., a consumer needing continuing care for diabetes, or expecting a baby wants to compare costs across providers). Another feature that we support adding to the calculator is the ability to incorporate consumers' resource use for prior year(s) based on claims data, personal health records, or other sources. This is a helpful feature as it is difficult for individuals, particularly those with chronic conditions, to track the number visits they made to their physician or prescriptions filled. Calculators should also estimate the average out-of-pocket cost for an episode of care (total cost of all treatments associated with a condition).

When combined with information about quality in a way that is easily understandable, information on costs will allow consumers to make value-based decisions on their coverage and care.

Make quality and cost data available for Medicaid and CHIP beneficiaries

The Affordable Care Act contains general provisions requiring Exchanges to supply information about the quality and cost of qualified health plans to consumers. These transparency requirements should be extended to Medicaid and CHIP populations. Although the Affordable Care Act directs Exchanges to facilitate enrollment for these beneficiaries, there are no parallel transparency requirements to support beneficiary decision-making.

Mobilize consumers to act upon quality information by helping them understand the implications of quality of care on their health

To motivate consumers to seek out health plans and providers of high-quality care, Exchanges must clearly explain what quality care means and the role that patients, providers, and plans can play in creating a high-quality, high-performing health care system. For example, although

consumers understand the importance of some of the individual elements that quality care encompasses (e.g., care that is coordinated, good communication among providers), they often do not associate them with the term "quality care." Consumers also assume that the responsibility for attaining quality care rests directly on their shoulders, not with the health system or their providers, and they are often unaware of the variability of quality among providers. Additionally, there is sometimes the incorrect assumption that higher cost means higher quality, and that more care means better care. Given these circumstances, Exchanges must take an aggressive role in advancing wide-spread consumer understanding of quality care.

Build upon the existing evidence on how best to convey quality and cost information to consumers (Questions C.5., J.1., J.2.)

Presenting information on quality and cost in a way that is understandable and actionable for consumers can be challenging. Fortunately, Exchanges can build on the work of others. There are efforts underway in different regions of the country that are dedicated to encouraging consumers to use quality and cost information in decisions about their care. Consumer advocates have been conducting research on how to best communicate quality and cost data to consumers, and assessing what they need to know to make the best choices possible. Employers and unions also have a long history in placing information on quality and value into the hands of their employees in a way that is actionable (e.g., explaining deductibles and out-of-pocket maximums, developing cost calculators, etc.).

Achieve immediate and long-term cost containment by incorporating the Affordable Care Act's value-oriented system changes for Medicare and Medicaid, sharing savings from increased coverage, and health plan product design (Questions E.1., E.2.)

Exchanges must take an active role in curbing health care costs, both in the short- and long-term, to ensure the sustainability of the health care system. The Affordable Care Act enacts a wide range of initiatives to address costs in Medicare and Medicaid, while maintaining or improving quality: accountable care organizations, medical homes, bundled payments, pilots to be launched by the Center for Medicare and Medicaid Innovation, the hospital readmissions reduction program, the hospital value-based purchasing program, the Patient-Centered Outcomes Research Institute, etc. Exchanges can extend their reach to the private sector by requiring qualified health plans to adopt reforms that prove successful. Exchanges can also help to advance cost containment in the private insurance market by facilitating collaboration between qualified health plans and employers and plans outside of the Exchange on payment pilots and other efforts. No single private payer can have a significant influence on provider behavior. By aligning payment policies with other commercial payers and the public sector, payers can send consistent signals to providers to supply safe, high-quality, and efficient care.

Where possible, Exchanges should ensure that providers' savings derived from expanded coverage of the uninsured are shared with the larger community. Currently, private insurers must pay higher provider reimbursement rates to make up for providers' uncompensated service to uninsured individuals. The creation of Exchanges will reduce uncompensated care and thereby reduce the need for cost-shift to private payers. We encourage Exchanges to monitor whether providers are decreasing their fees to reflect lower uncompensated care costs.

Exchanges should also permit health plans to:

- Reward "high value" treatment choices and disincentivize treatments where evidence suggests that the treatments will not reduce risk or improve outcomes;
- Use tiered networks that focus on high value providers, using a quality and cost formula for designation;
- Employ reference pricing models that identify the appropriate costs for services and design benefits to incentivize consumers to use providers supplying services within the reference price; and
- Require providers to use health information exchanges, registries, and clinical feedback systems support.

Encourage a strong foundation for primary care and care coordination (Questions E.1., E.2.)

The Affordable Care Act requires qualified health plans to enact a quality improvement strategy that provides increased reimbursement or other incentives for implementing activities to: improve health outcomes; prevent readmissions; advance patient safety and reduce medical errors; promote wellness and health promotion; and reduce health and health care disparities. An underlying component to the success of many of these activities is having better primary care and more integrated care, both of which can be facilitated by Exchanges. Exchanges should require qualified health plans to emphasize quality improvement strategies that improve the internal infrastructure of primary care practices, pay more for primary care, increase access to primary care services and pay differently for care (i.e., move away from fee-for-service reimbursement to value-based payment). Qualified health plans could, for example, adopt the following strategies:

- Provide financial rewards to providers for integrating health information technology into everyday patient care in a way that aligns with or complements the meaningful use program;
- Increase payment for primary care practitioners and shift payment away from specialists;
- Remove financial barriers that impede patients from obtaining appropriate primary care services (e.g., out-of-pocket costs);
- Assure that networks provide adequate access to primary care practitioners;
- Test innovative care models (e.g., medical homes, accountable care organizations, etc.) and broadly implement successful programs that maintain or improve quality while reducing costs; and
- Provide technical assistance to primary care practices and support primary care practices in redesigning their clinic processes.

We recognize that beyond these recommendations much more must be done in other settings to support primary care and care coordination, including changes to medical education requirements. For those quality improvement strategies that encompass wellness and disease management programs, Exchanges must consider whether the programs may have unintended consequences, such as widening existing disparities. HHS should set out clear metrics for quality improvement strategies – with clear goals and benchmarks – so that plans can be held accountable for their results, and consumers and employers can know whether plans are meeting quality and cost targets over time.

Encourage the reduction of disparities

Qualified health plans should stratify their provider performance data by race, ethnicity, preferred language, and gender. This information will support the identification of disparities and should be used be qualified health plans to foster quality improvement.

Customize information to meet the needs of individual consumers (Questions C.5., J.1., J.2.)

Consumers' informational needs vary and Exchanges should tailor information and tools to reflect these differences. For example, consumers in the Exchanges will have different literacy levels, language preferences, and health needs. To facilitate better understanding of health care coverage and provider selection for the diverse populations, Exchanges should:

- Present information in a consumer-friendly, sufficiently standardized way to facilitate easy comparisons of options (e.g., use clear, concise language written at the lowest reasonable education level, employ consistent terminology and plain language definitions of health care terms, etc.).
- Test with consumers new, innovative models for communicating information (e.g., PDAs, etc.).
- Make online decision aids accessible and usable for a wide range of consumers (e.g., intuitive and alternative layers of decision support to meet the diversity of consumer needs and capabilities).
- Direct those with conditions that lend to preference-sensitive treatment to decision support tools. A plan's disease management programs, cost saving opportunities, and coaching may be particularly helpful to these individuals.

Balance the need for standardization to facilitate comparability across health plan products with the need for innovation (Question E.1.c.)

Standardization is necessary for comparability and is a vehicle, along with minimum requirements, for ensuring that consumers get useful and meaningful information. However, local Exchanges should be permitted to innovate and provide information that is useful to particular populations of consumers, due to demographic and geographic variations in consumer needs and the nature of local delivery systems.

In closing, the perspectives of consumers and employers must be reflected in the governance and design of Exchanges. On behalf of consumers and purchasers across the country, thank you for your efforts and your responsiveness to our comments. If you have any questions, please don't hesitate to contact either of the Disclosure Project's co-chairs.

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