

# Health Insurance Exchanges, Quality and Value



# Agenda

- A value agenda – something more and more states (Oregon, CA) and larger purchasers taking on
- Quality measures, reporting and health plan rating
- Accreditation

# Opportunities to Drive A Value Agenda in Exchanges

1. Choice architecture – “Nudge” consumers towards best value options
2. Benefit design
  - Foster value-based designs that steer people to better options
  - Integrate patient activation tools
3. Network design
  - use quality and cost measures for tiering
4. Health plans as “market makers”
  - Health plans can be change agents, supporting (with data) and driving (with payment) improvements in care delivery

# Models and Functions of Exchanges

Core Exchange Functions	1.State-Based Exchange	2. State-Partnership Exchange	3. Federally-Facilitated Exchange
<b>Consumer Assistance</b> • Education, outreach	State	State or Federal	Federal
<b>Plan Management</b> • Plan selection, monitoring • Collection of plan data	State	State or Federal	Federal
<b>Eligibility</b>	State	Federal	Federal
<b>Enrollment</b>	State	Federal	Federal
<b>Financial Management</b>	State	Federal	Federal

# QUALITY MEASURES

# Who Are the Exchange Enrollees?

(Source: Kaiser Family Foundation)

- The projected 2019 Exchange population is relatively older, less educated, lower income, and more racially diverse than current privately-insured populations
- Most enrollees transition from being previously uninsured; many currently experience access barriers
- They report worse health but have fewer diagnosed chronic conditions than current privately insured populations
- Per capita health spending might look similar to health spending among Americans insured through an employer
- Much lower income than the projected non-Exchange non-group population

# Quality Measures: A National Starter Set

- Use the same quality standards nationally
- Start with a feasible set of measures; can add over time
- Select measures using defined principles
  - Aligned with national health improvement goals, Medicaid, Medicare and commercial strategies
  - Widely used by health plans and national quality reporting initiatives
  - The same measures for all types of health plans – HMOs and PPOs
  - Phase in more outcomes measures over time
  - Require auditing to ensure reliability, validity of results
- Require CAHPS, a proven method of gathering patient experience; may need new items

# Quality Measures for Exchanges

- Various levels of requirements
- Waiting for federal and state rules
- Quality measure reporting options
  - Separate Exchange population

- Exclude measures with low prevalence

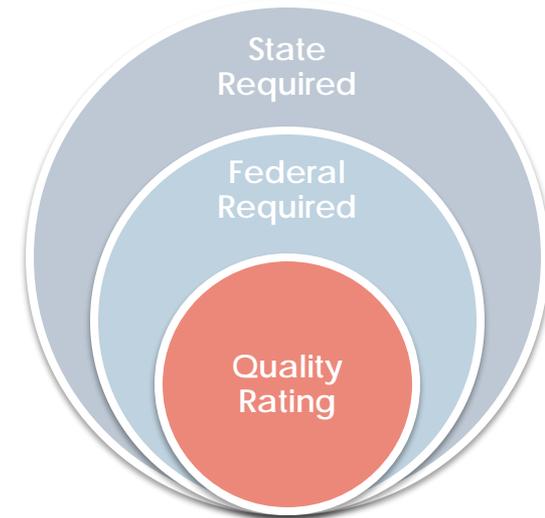
- Composites

- Rolling average

Small numbers

- Combine Medicaid or Commercial with Exchange populations

- NCQA will align our data collection, reporting, Accreditation with requirements
  - Could include non-HEDIS measures



# ACCREDITATION

# Health Plan Qualification

- The Exchange will qualify health plans (QHP) who meet the following requirements:
  - Are **accredited** within a specific timeframe
  - Meet marketing requirements
  - Ensure a sufficient choice of providers (network adequacy) and provide information on providers
  - Include essential community providers where available
  - **Implement quality improvement strategy**
  - **Report health plan quality measures**
  - Utilize uniform enrollment form
  - Utilize standard format for presenting benefit options

# Where We Are

Developing Concepts/  
Revising Design



Draft Standards/Design  
February 2012



Accreditation  
Released July 2012

# Accreditation Requirement

- Issuers must be accredited to participate in Exchange (certified)
- Accreditation can be a cost effective way to:
  - Assure plans keep up with best practices
  - Avoid using scarce state resources to keep plans up to date

# Phase-in of Accreditation Requirement

- Will defer to federal requirements, but NCQA recommends
  - Allow one additional year- must be accredited by 6/30/2014
  - Allow issuers with existing accreditation (commercial or Medicaid) to participate in Exchanges until their accreditation expires
  - Regardless of accreditation product line, all must be accredited based on Exchange measures (HEDIS/CAHPS) by 9/2015

# Transition pathways

	2014 Qualification (6/2013)	2015 Qualification (6/2014)	2016 Qualification (6/2015)
New health plan (legal entity less than 36 months old)	Demonstrate scheduled for Accreditation	Exchanges (standards only) Accreditation	Exchange (standards + HEDIS+CAHPS) Accreditation
Existing health plan, new to Accreditation	Demonstrate scheduled for Accreditation	Medicaid or Commercial or Exchanges (standards only) Accreditation	Exchange (standards + HEDIS+CAHPS) Accreditation
Existing health plan, with Accreditation for Commercial or Medicaid product line (health plan operates the same for all products)	Medicaid or Commercial Accreditation	Medicaid or Commercial or Exchanges (standards only) Accreditation	Exchange (standards + HEDIS+CAHPS) Accreditation
Existing health plan, with Accreditation for Commercial or Medicaid product line (health plan operates differently)	Demonstrate scheduled for Accreditation	Exchange (standards only) Accreditation	Exchange (standards + HEDIS+CAHPS) Accreditation

# Questions Around Accreditation

- Should there be different statuses for the different scenarios?
- Should statuses be reported out to consumers on Exchange?
- Is there a pre-qualification review that new health plans and health plans without Accreditation should meet to qualify (6/2013)?

# Concept Input Survey Results

- 27 Organizations (19 health plans and a TPA, 4 regulators, a purchaser, a consumer and anonymous)
- 58% of plans (11) definitely plan to participate in an Exchange, while the remaining are still considering
- Overwhelming majority basing Exchange product on Commercial product

# Non-Discrimination in Marketing

Should NCQA add/modify our HPA standards to address:

## Requirement:

Health plans must meet marketing requirements and not employ marketing practices or benefit designs that can discourage enrollment by individuals with significant health needs

## Survey Feedback

- Regulators/Consumers say yes
- Health plans say no: 75%
  - Monitoring should continue to occur at state/federal level

# Network Adequacy

Should NCQA add/modify our HPA standards to address:

## Requirement:

The legislation requires network adequacy standards for Exchanges to ensure that QHP provider networks provide sufficient access to care. Standards focus on provider availability, geographic access, and # of physicians accepting new patients

## Survey Feedback

- Regulators/Consumers say yes
- Health plans say no: 73%
  - Regulatory requirements already exist
  - Too much geographic variation
  - NCQAs current standards are adequate

# Quality Improvement Strategy

Should NCQA add/modify our HPA standards to address:

## Requirement:

Implement QI strategy that rewards quality through the use of market-based incentives for the following:

Improves health outcomes

Reduces disparities

Wellness and health promotion

Reduces readmissions

Improves patient safety

## Survey Feedback

These strategies should include:

- Public reporting – 79%
- Tiered networks – 66%
- Provider reimbursement - 60%
- Direct rewards to members -53%

# Summary

- Regardless of purchaser model, opportunities to drive value through choice architecture
- Quality measures – start with core and grow over time
- Accreditation – transition needed, perhaps combine with quality improvement strategy