Policy Brief #5: Driving Quality and Cost Improvements through the Exchange

A health care exchange that pools its enrollees' bargaining power will help give consumers a better deal on their coverage, but it will need to do more to get the unsustainable rise in health care costs under control. That is because while consumers and businesses pay plenty in premiums and out-of-pocket costs, much of our health care spending does not yield the results that we really want—healthier people. The payment systems used by major insurers, both public and private, are one root of this problem. The widely used fee-for-service payment approach rewards providers for the number and complexity of tests and procedures that can be billed, not the quality of care provided or whether the patient gets healthy.

Fortunately, research and the experience of innovative providers across the country have charted a path toward medical care which can better rein in costs and improve patients' health. To take that path, providers, rather than spending all their time on an endless stream of paperwork, need to be able to devote more time to their patients. Primary care physicians need to be able to work as a part of a team coordinating with a patients' other health professionals so that patients get all the care they need while avoiding unnecessary, duplicative, or harmful tests and procedures. And providers need easy access to updated medical records.

But providers will never achieve these wholesale changes in the delivery of care until payers change the way they pay for care. Insurers will need to move towards paying for quality and results, not volume. And the exchange, in its negotiations with insurers, can drive them to adopt these proven strategies, which will improve enrollees' health and lower overall health care costs.

About this Series:

The creation of a new health insurance exchange offers states an opportunity to improve health care and lower costs by pooling consumers' bargaining power, creating economies of scale, and pushing insurers to delivering lower costs and higher quality. PIRGIM's *Building a Better Health Care Marketplace* project provides recommendations to advocates and policymakers for how to create a strong, pro-consumer exchange. Support for the project is generously provided by the Robert Wood Johnson Foundation. For further information on this project, and other policy briefs in this series, please visit http://www.pirgim.org.

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Strategies to Achieve System Change

Medical Homes: This approach improves the quality of care and brings down costs by encouraging primary care physicians to work closely as a team with other specialists and health professionals. A team of professionals, led by a doctor or nurse practitioner, would be compensated for coordinating all of a patient's care, not just for the number of visits they have or tests they order. That team would have the time and resources needed to deliver the best care. By using electronic medical records, they would also help reduce medical errors and unnecessarily duplicative tests that can happen when one of a patient's doctors is unaware of what the other is doing. The burden of keeping track of tests, prescriptions and treatments will no longer fall solely on a sick patient.

Chronic Disease Management: Chronic disease management is a systematic approach that focuses on promoting a combination of behavior changes and clinical treatments to prevent chronic conditions from causing expensive health emergencies. For example, programs aimed at diabetes patients can closely monitor diet and other health indicators, to help the patient live a stable life rather than having to be rushed to the hospital for costly emergency surgery. While studies continue to evaluate these programs, research suggests that properly designed disease management programs can successfully reduce costs.

Accountable Care Organizations: Best exemplified by high quality, low-cost providers like the Mayo Clinic, Intermountain Health in Utah, or Geisinger Health in Pennsylvania, Accountable Care Organizations (ACOs) integrate the care patients receive across the medical system. Rather than hospitals, physicians and other providers each paid separately for individual treatments, under this model all three entities are all part of a single system which shares the payment for the patient's entire course of treatment and is accountable for the health and outcomes of the patient. In many cases, this allows doctors to be paid by salary, rather than through piecework fee-for-service rates, and creates additional rewards for improving patient health and reducing unnecessary costs.

Bundled Payments: This innovation replaces itemized fee-for-service payments with a single, bundled payment for all treatments, tests, and procedures a patient receives for a given condition. Hospitals, physicians, and other providers who have treated a patient are together reimbursed by a set amount for every patient admitted with a particular diagnosis (which can be adjusted upwards if the patient is especially high-risk and likely to require more extensive treatments). The providers share the payment, so that they are rewarded for delivering high-quality, effective care that ensures the patient will not be quickly readmitted for the same complaint. Properly structured bundled payments can generate enormous cost savings.

Exchanges and the Path to Lower Costs and Higher Quality

These innovative approaches to delivery system reform can result in improved patient care and lower costs. In Medicare, the Affordable Care Act phases in these reforms over the next several years. But if these changes are to extend beyond that single program, so that all consumers can receive their benefit, state policymakers should use their exchanges to drive insurers to adopt these reforms, so that for example they pay providers via bundled payments where appropriate, or reimburse primary care doctors for leading a medical home team.

States must act to ensure that state exchange have the authority to negotiate with plans and set high standards which insurers will need to meet in order to participate in the exchange. While these tools could simply serve as a device to bargain down premium costs over the short term, the possibilities are much broader. Exchanges can also use that authority to accelerate system change that will bring down costs over the medium- to long-term.

The exchange could have a variety of mechanisms at its disposal in accomplishing these goals. If the exchange requires plans to submit competitive bids to participate, the extent and quality of cost-saving reforms should be a required element of every insurer's bid. And in the same way that exchanges can negotiate lower premiums as a condition of entry onto the exchange, the exchange should use its bargaining power to push plans to aggressively implement these reforms.

To give any real advantage to the exchange in these negotiations, the exchange must have the ability to say no and to exclude those plans that refuse to take steps to lower costs and improve quality for consumers. It is for this reason that the "all-willing sellers" model for the exchange, often advocated by insurers and other industry interests, is simply inadequate. If a state exchange must accept all comers, it has given up the advantage it needs to insist that plans adopt these critically important system change reforms.

Translating Policy into Results

The exchange's efforts cannot stop once plans have agreed to incorporate these reforms. The exchange must demand strong performance from insurers, and evaluate whether these new policies are accomplishing their goals.

State exchanges should have the authority and resources to monitor plans' compliance with their commitments. Insurers should be required to disclose information on the impact of the reforms they have adopted on quality of care and coverage, cost, outcomes, adherence to best practices and other appropriate information, to allow the exchange to evaluate the effectiveness of their programs. And the exchange should consider this

information when considering the plans' participation in the exchange in the future.

Empowering the Consumer

The last ingredient needed for an exchange that delivers lower costs and higher quality is a strong role for the individual consumer. The Affordable Care Act requires exchanges to provide a web site where consumers can compare and shop for the plans that is right for them, and requires that it provide some level of price and quality information. But states should go further.

Exchanges should provide easily understandable information about what delivery reforms like medical homes, accountable care organizations, and chronic disease management mean and how consumers can best make use of them. States should also consider providing a special “seal of approval” that would be visible on the exchange website for those plans that do the best job of promoting high-quality and low-cost care. Policymakers should insist that more detailed metrics evaluating the quality of care and coverage, outcomes, adherence to best practices and other appropriate information be available to consumers through the exchange website. Finally, as wide a variety of this information as possible should be available for exchange plans, but customers should be able to access that information easily and understandably.

Towards a Coordinated Strategy on Costs and Quality

The exchange will not be the only active purchaser of medical care in the state. Other payers, such as large employers, public employee plans, the state Medicaid plan and union trusts, will likely also be developing their own initiatives to reform how they pay for care. By working together and aligning these programs, states can even more effectively drive positive change in the health care market, so that providers do not have to change their practices to respond to a variety of slightly different reform initiatives. Exchanges can play a strong leadership role in convening these multi-payer initiatives and making them effective. States should consider building into their exchange mechanisms allowing it to coordinate with other large purchasers to drive positive change in the marketplace.

Additionally, some of these large purchasers, particularly those using public dollars to purchase care—such as the state’s public employee benefits plan—may want to explore merging with the exchange to further consolidate purchasing power, and expand the marketing leverage available to both.