

Raising the Bar:

Strategies to contain cost and improve quality in Oregon's health insurance exchange

Oregon's new health insurance exchange has the potential to rein in the rising cost of health insurance and the underlying cost of care, while improving quality and giving consumers better choices. In fact, the law that created the exchange gave it a specific mandate to do just that.

Among the exchange's most powerful tools to meet this mandate are its ability to set standards for "Qualified Health Plans" (QHPs) – the insurance plans the exchange makes available to small businesses and consumers – and its ability to rate and rank QHPs to inform consumers and encourage competition on price and quality.

It is important that the exchange build in strong standards, ratings and rankings from the beginning to do everything it can to drive a better deal for consumers. While exact standards and rating metrics are sure to change and become refined with time and experience, there is no reason to delay implementing strategies that have already been proven to improve quality and lower costs. In fact, given the rising cost of insurance and out-of-pocket costs squeezing Oregon's families and small businesses, the exchange has an imperative to prioritize this critical work.

In the recommendations below, we discuss policy options that would help ensure the exchange delivers on its promise to Oregon consumers. These recommendations build upon the substantial work on quality in health exchanges by National Committee for Quality Assurance (NCQA)¹, the Georgetown University Health Policy Institute² and Kaiser Permanente.

Strategies to bend the cost curve and boost quality

Done right, health insurance costs can be contained not by raising deductibles or cutting access to care, but by cutting waste in the insurance and health care systems, and by improving care to keep people at their healthiest.

We recommend that the exchange adopt Qualified Health Plan quality standards and metrics consistent with those established through Oregon's Medicaid transformation process, and have these metrics be the same as those used in the quality ratings that consumers see when

¹ <http://www.ncqa.org/LinkClick.aspx?fileticket=eeHZOSSiOD0%3D&tabid=36>

² <http://www.rwjf.org/files/research/72851qigeorgetownexchange20110928.pdf>

choosing a plan. We recommend the exchange require QHPs to develop specific, detailed strategies to meet these cost and quality metrics.

Under the Affordable Care Act, plans available on exchanges are required to have *at least one* Quality Improvement Strategy, which is defined as a payment structure that provides increased reimbursement or other incentives for the activities listed below. It is important to note that all of these activities are associated with reducing costs as well as improving quality.

The ACA has been interpreted to require that QHPs incorporate only one of these activities. We recommend Oregon build on this federal standard by clarifying that the strategy must incentivize *all* of the activities listed, and that the strategy must entail both containing costs and improving quality:

- (A) improving health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage;
- (B) the implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;
- (C) the implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage;
- (D) the implementation of wellness and health promotion activities; and
- (E) the implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings.

—(PPACA, Section 1311 (g))

The strategies and activities listed above should be updated annually to include new developments proven to improve quality and/or reduce costs. Shared decision-making is an example of an activity that Oregon should consider adding to the above list. In addition Oregon may want to clarify that payment structures include not only reimbursement structures, but also benefit design, provider contracting and network design.

In addition, Oregon's exchange should set additional standards to codify the best in current industry practice, and build on the strengths of Oregon's insurance market:

- No plan in the exchange should reimburse for so-called “never events”.

- QHPs should be required to exclude providers who have the worst records for preventable hospitalizations and readmissions.
- No plan offered in the exchange should have a medical loss ratio (as defined by federal regulations) below a level set by the exchange—perhaps 85% for plans with effective dates beginning Jan 1, 2014. The exchange should continually evaluate this level and raise it as needed if medical trend continues to outpace inflation and to encourage insurers to increasingly improve efficiency.

In addition, the exchange should consider requiring each QHP to set a specific, quantifiable goal for reducing their medical trend in the year ahead and in years moving forward, supported by a description of the strategies the insurer will use to meet that goal. The insurers could then be held accountable for meeting these goals.

Insurers are already required to describe their cost containment and quality improvement strategies in their rate filings with the Oregon Insurance Division, and the exchange could expand upon this practice to provide insurers with greater incentive to invest in evidence-based approaches to bending the cost curve for quality care.

Accountability and Enforcement

Plan standards are only as good as the enforcement structures behind them. Oregon's exchange is empowered to evaluate adherence to its standards, and this evaluation needs to have teeth for the Exchange to be effective in lowering costs or improving quality.

Plans that consistently lower their medical cost trends, while exceeding quality outcome standards, should be rewarded—through preferential listing or an extra star in the plan rankings seen by consumers, for example.

Similarly, for plans already in the exchange, there should be consequences if they fall below quality standards or fail to demonstrate that they are putting adequate effort into bending the cost curve.

In some cases, it may be appropriate to decertify the plan, and remove it from the exchange. This should be considered a last resort, however, as decertification may force consumers to change coverage. The Exchange should explore the range of options for sanctions short of decertification, which could include probationary periods, remediation agreements, mandated rebates to consumers, and a “red flag” or other indication in the plan rankings that consumers see.

It will also be important for the exchange to be able to meaningfully evaluate each plan's cost containment and quality improvement strategy. In its initial application for plan certification,

and on an ongoing basis each year, plans should be required to submit a standard streamlined form in which they:

- Describe their cost containment and quality improvement strategy;
- Quantify each numerical cost containment and quality improvement goal for the year ahead;
- Detail the methodology used to develop each goal and strategy;
- Identify pilot activities and hypotheses around results; and
- Quantify the actual cost containment and quality improvement results for each area for the previous year, and make this information publicly available.

The exchange should evaluate the strength of these strategies and goals, and the methodology behind them, and consider progress toward goals as part of the recertification process. If a plan fails to demonstrate it has a meaningful strategy, the exchange should take action up to and including decertification, especially if the plan is also failing to meet quality metrics.

The exchange should evaluate QHP cost containment and quality improvement strategies to determine whether they are achieving success in improving health outcomes for Oregonians, not only to determine whether QHPs are meeting the goals laid out by the insurers themselves. The exchange can most effectively encourage innovation when it can evaluate different strategies against outside, objective metrics and compare different plan strategies against each other to work toward identifying and promoting best practices.

The exchange should work to include consumers in its process of evaluation, not only to determine consumers' opinions about their own coverage but to give consumers a meaningful role in the decision-making processes of the exchange. The exchange should consider establishing a special consumer advisory committee for this purpose.

Consumer Choice and Plan Standardization

It is critical to the proper functioning of the exchange, and in the interest of health insurance consumers and small businesses, for consumers to have meaningful choices between health plans. If the exchange does not enable choices that are meaningful for consumers, it will not be able to foster competition on cost and quality between plans, and it will not add value to the health insurance marketplace for consumers.

What does meaningful choice mean? Information must be presented in plain language and consumers must be able to compare plans in a way that will be meaningful given their preferences. Consumers cannot be expected to wade through lists of marginal differences between cost-sharing structures, but they can be expected to understand and make trade-offs between significantly distinct plans presented in a way that allows them to compare apples to apples.

“Apples to Apples”

Plan standardization is part of ensuring that consumers have meaningful choice. Without it, it is not possible for consumers to make apples-to-apples comparisons. By “standardization” we mean that every plan in the “Bronze” tier, for example, would have the same basic benefit features – same co-pay, deductible, co-insurance, and out-of-pocket-maximum. With standardization in place, the consumer can then compare those features that matter most: the plans’ premiums, provider networks and quality rankings.

Standardization could take one of two forms:

- All plans could be standardized (“cookie-cutter” plans) at each metal tier, and no non-standardized plans could be allowed. This is the true “apples to apples” comparison model; or
- All carriers could be required to provide a standardized plan at each metal tier but allowed to provide other plans, with different cost-sharing, as well. This option may work, but consumers may become frustrated with trying compare numerous “actuarially equivalent” benefit plans. In addition, there is risk that insurers may use non-standard benefit designs to try to attract only the healthiest enrollees and avoid those with pre-existing conditions.

Although it is impossible to determine what the perfect number of plans for Oregon’s exchange would be without further study, Oregon can draw on the experience of Massachusetts, where consumer demand eventually led to a greatly reduced number of plans.³ If the exchange chooses to err in the direction of allowing a wide range of plans, it is important that the exchange plan for this eventuality in advance and strategize ways to minimize the associated coverage disruptions for consumers. But there is no reason to subject Oregonians to the risk of such disruption unnecessarily when we have an evidence-based and experience-tested model for an appropriate range of plans already available to us.

Total costs

When choosing between plans, especially between metal tiers, consumers need to be able to understand the total costs they might have to pay. That means the exchange needs to clearly show not just the premium, but the deductibles and other out-of-pocket costs. Consumers new to the health insurance market might be misled by a low premium if their additional cost-sharing obligations aren’t clear.

Oregon’s exchange should follow recommendations from experts such as Consumer Reports, whose research found that the best way to explain this is by showing estimates of what the

³ <http://bluecrossmafoundation.org/Health-Reform/Lessons/~media/Files/Health%20Reform/Lessons%20for%20National%20Reform%20from%20the%20Massachusetts%20Experience%20Benefit%20Designs%20Toolkit%20v2.pdf>

plan pays and what the enrollee pays for common conditions like managing diabetes, or having a baby.⁴

Quality ratings and rankings

Quality rating and ranking are important tools to give consumers information about plans they are comparing. A strong ranking system is one of the best ways for the exchange to direct consumers to high-value plans and encourage the kind of competition between insurers that the exchange was designed to foster.

We recommend quality rating be connected with the quality metrics that plans must meet, and that both be coordinated with metrics currently under development through Medicaid transformation. These should be existing, independent, well-established, audited measurements of quality and service such as HEDIS performance measures and CAHPS customer experience ratings. This information should be conveyed through visual cues like star ratings or letter grades, so consumers can easily find value.

Consumers should be able to see overall ratings of plans, similar to how Consumer Reports provides an overall rating based on NCQA's ratings. And consumers should be able to drill down into the separate ratings that make up the overall rating.

In addition, we support preferential listing of plans, with those ones with the highest overall quality ratings and lowest costs on top. It is in the best interest of consumers, and the overall health of the market, for insurers to compete for those top "high value" spots.

A plan should receive a high preferential ranking if it provides consumers with a high value proposition—if it gives consumers more for their money—and this should be made very clear. If the purpose of the ranking system is not crystal-clear to consumers, it holds the potential to be useless or even misleading. If the system is inadequately explained or the web portal is poorly designed, a consumer could easily mistake rankings (or quality ratings) for an evaluation of some other metric, such as price—e.g., purchasing a low-rated plan in the mistaken belief that it would be cheaper.

The quality of health insurance for consumers is inseparable from the quality of care itself and the quality of the hospitals and professionals providing that care. While the exchange has no direct authority over health care providers, it should find ways to incorporate provider quality measures into its evaluations of QHP quality. The exchange should also work to create tools for consumers that incorporate quality ratings of providers, to build stronger consumer choice and encourage competition on quality.

⁴ http://yourhealthsecurity.org/wordpress/wp-content/uploads/2011/08/A_New_Way_of_Comparing_Health_Insurance2.pdf

Conclusion: Give the exchange the tools it needs to live up to its promise

Oregon's health insurance exchange could be genuinely transformative for individuals and small businesses struggling with the ever-rising cost of care, but only if it is done right. To fulfill its statutory mission to contain costs while improving quality, the exchange must:

- Hold participating plans to high standards designed to bend the cost curve;
- Hold participating plans accountable for adopting and successfully executing evidence-based strategies to improve quality and reduce the underlying cost of care;
- Provide consumers with meaningful choice by ensuring that they can compare plans apples-to-apples;
- Present total cost information transparently and in a user-friendly format; and
- Rate and rank plans in a clearly-defined and clearly-presented fashion to provide consumers with the most detailed and accurate information available about quality and foster genuine competition between plans.

Adopting strong framework at the outset will ensure that the exchange is in the best possible position going forward. Any standards that cannot be implemented immediately should be put on a clear, benchmarked timetable for future implementation to create certainty for consumers, insurers and providers.

With the purchasing power of hundreds of thousands of Oregonians behind it, the exchange has the power to build better value for consumers, but it can only live up to its promise if it works from the beginning to raise the bar for health insurance in Oregon.