

# The Role of Exchanges in Quality Improvement: An Analysis of the Options

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## Executive Summary

*The Patient Protection and Affordable Care Act (ACA) expands coverage under Medicaid and provides new coverage options through state-based insurance exchanges, with a goal of reducing the number of uninsured in this country by more than half. At the same time, the ACA undertakes a number of reforms aimed at increasing the quality and value of health care by targeting health services organization, delivery and payment in public coverage programs like Medicare and Medicaid. Because an exchange can aggregate the purchasing power of individuals and small groups, it holds the potential to be an important mechanism for extending those quality and delivery system reforms to the private health insurance market, as well as to the providers who serve beneficiaries in public programs and patients who are privately insured.*

This paper attempts to describe options states could pursue to use their exchange to help drive quality improvement and delivery system reform. We found a handful of states to have a strong interest in doing so, particularly those that have had a longstanding focus on promoting quality and value in their state's health care

delivery system. But these and other states recognize that their first priority in establishing and maintaining an exchange is to attract health plans and enrollees, and to meet the minimum standards required by the ACA.

We explore the potential for exchanges to help drive broader changes in the way health care is paid for and delivered, and describe issues states should consider in undertaking these delivery system reforms. We conclude that states can benefit from federal support and direction, and can take steps now to develop the necessary infrastructure and governance to permit an exchange to undertake these efforts in the future. Selected findings include the following:

- **The ACA presents states with multiple opportunities to develop an exchange that promotes delivery system reform at both the plan and provider levels.** At a minimum, states must ensure plans participating in exchanges meet the quality improvement criteria established under the ACA. Exchanges must also display quality and cost ratings for participating plans. But states can go further.
- **States have a number of options for using their exchange to help drive quality improvement and delivery system reform.** These include:
  - › Providing plan performance information on specific quality metrics important to consumers, so that they can more easily assess which plans do a better

job providing the services they want, (i.e., managing diabetes or high blood pressure). Exchanges can also set quality standards for plans beyond those required by the ACA;

- › Align quality improvement and reimbursement strategies for the exchange, Medicaid, Children's Health Insurance Program (CHIP), state employee benefits programs and, possibly, private employer purchasing alliances, so that a critical mass of health plans are sending a common set of signals to their provider networks; and
- › Use the exchange's web portal to give consumers relevant and actionable information on plan and provider quality, and use web-based decision support tools to promote higher-value plans as consumers consider their plan choices.
- **States working to establish insurance exchanges must initially focus on core, foundational issues critical to the exchange's survival, such as building a modern information technology (IT) infrastructure, mitigating adverse selection, and managing fragile stakeholder coalitions that will remain invested in the exchange's success.** However, while states address these fundamental tasks, they can lay the groundwork now to allow an exchange to undertake quality improvement efforts and align with future quality improvement and delivery system reform efforts in the state. Most importantly, state legislators and leaders should avoid limiting the exchange's authority and resources to pursue quality improvement and delivery system reform in partnership with other state actors and leaders in the employer-purchaser community.
- **As with any effort to promote quality improvement and delivery system reform, states will need to involve providers, employers, consumers, and other interested stakeholders in the development of policy options and execution of any reforms.** State and exchange leadership will need to work to build the broad support and strong stakeholder leadership needed to drive and sustain a quality improvement agenda.
- **While some states may have difficulty undertaking this on their own in a sustained and effective manner, the federal government has a number of opportunities to complement and support state efforts.** These include:
  - › Using federal establishment grants to cover some of the costs associated with the infrastructure and personnel needed to operationalize quality improvement strategies;
  - › Incorporating exchanges into the National Quality Strategy;
  - › Building on Medicare Advantage's work with quality rating and bonus payments;
  - › Creating complementary incentives through the Federal Web Portal (healthcare.gov); and
  - › Avoiding policies that could unintentionally undermine the exchange's initiatives, such as exempting multi-state plans from quality improvement or delivery system requirements.

## Introduction

The Patient Protection and Affordable Care Act (ACA) expands coverage under Medicaid and provides new coverage options through state-based insurance exchanges, with the goal of reducing the number of uninsured in this country by more than half.<sup>1</sup> At the same time, the ACA undertakes a number of reforms aimed at increasing the quality and value of health care by targeting health services organization, delivery and payment in public coverage programs like Medicare and Medicaid. Because an exchange can aggregate the purchasing power of individuals and small groups, it holds the potential to be an important mechanism for extending those quality and delivery system reforms to the private health insurance market, as well as to the providers who serve beneficiaries in public programs and patients who are privately insured.

There are good reasons for states to think about using their exchange as one of many levers for quality improvement and delivery system reform. First, while some large employers have been working to encourage provider-level delivery system and payment reforms through their contracts with health plans, individual and small group purchasers have been largely absent from those efforts because they haven't had the infrastructure, capacity, or market leverage to participate. An exchange can provide a forum for aggregating those individuals and small groups to leverage improvements by contracting for higher-value health care, much as a human resources department might for a large employer.

Second, for state purchasers such as Medicaid and state employee benefits agencies, exchanges can help catalyze system reforms by joining with those agencies to develop common goals for improving health outcomes and lowering costs, and then devising coordinated purchasing strategies that align incentives for participating health plans and through them, to providers. As one large health benefits purchaser noted, "Just negotiating on price with an

insurance company is not sufficient. Active purchasing is an opportunity to get at what's underlying the trend. You have to get down to the provider and the member level."<sup>2</sup>

Third, people's circumstances change, and as many as half of a state's lower-income residents will have income changes that require them to shift between Medicaid and subsidized exchange coverage.<sup>3</sup> Others will shift between the exchange's subsidized coverage and an employer's health benefit plan. To the extent that those individuals receive high-quality care throughout their lives that improves their health status, it should result in benefits not just for state Medicaid finances, but also for the state's employers who require a healthy, productive workforce.

Fourth, the ACA amends the Public Health Services Act (PHSA) to encourage attention to quality improvement activities on the part of all private health plans. The implementation of these amendments is occurring at the same time as preparation for the exchanges is underway. Therefore, state exchange planners miss an opportunity to promote higher-value health plans if their planning efforts don't take into consideration quality improvement work occurring in parallel under the ACA.

This paper explores the potential for exchanges to help drive broader changes in the way health care is paid for and delivered, and describes issues states should consider in undertaking these delivery system reforms. We also discuss ways in which the federal government can support states that pursue this strategy. To prepare this brief we conducted a review of primary and secondary source materials and conducted interviews with a selection of state officials working to incorporate quality improvement into exchange planning efforts, as well as national health policy experts. In some cases those officials asked to remain anonymous. The findings in this paper are the authors' alone and should not be attributed to any individual or group with whom we spoke.

## Quality Improvement Under the ACA

One of the goals behind enactment of the ACA is to improve the quality and efficiency of the delivery of health care services to patients and families. The law primarily attempts to achieve this goal through the development and implementation of new models of care, and new ways to pay for care, that transition away from a system that rewards providers for the volume of services they deliver, instead rewarding them for better coordinating and managing care, particularly for patients with chronic conditions. The law also attempts to encourage a more unified, strategic approach to quality improvement and delivery system reform through the development of a “National Quality Strategy” that, for the first time, requires the federal government to set priorities and goals for improving the quality of care and devise a strategic plan for achieving them.<sup>4</sup>

As required by the law, the administration released a draft strategic plan earlier this year.<sup>5</sup> While many of the strategies it outlines build upon private-sector initiatives, the primary levers for the federal government to implement that strategic plan are federally run and subsidized public insurance programs: Medicare and Medicaid. The two programs cover more than 91 million people, resulting in considerable purchasing power with providers.<sup>6</sup> As a result, the ACA leverages the market clout of the public coverage programs to encourage quality improvements and greater efficiency through programs, such as quality reporting initiatives, the development and use of “patient-centered medical homes,” tests of new payment models that encourage better care coordination and provider efficiency through “accountable care organizations” (ACOs), and payment incentives to reduce hospital readmissions.<sup>7</sup>

While the federal government develops, tests, and implements these quality and delivery system improvement programs in federally run and subsidized coverage programs, the ACA envisions that similar reforms will be taken to scale in the private market. Thus, a number of provisions in the law encourage private health plans to develop and implement a similar set of quality improvement programs.

### Medical Loss Ratio

In establishing new standards for the minimum portion of revenue that insurance companies must spend on patient care, drafters of the ACA demonstrated their intention to ensure that those companies maintain or expand their expenditures on quality improvement activities. Under new “medical loss ratio” (MLR) standards, insurance companies must spend a minimum amount of premium revenue on health care goods and services, or pay a rebate to policyholders.<sup>8</sup> Insurers that sell to large groups (100 or more employees) must spend at least 85 percent of premium revenues on health services, and companies that sell to smaller groups (fewer than 100 employees) and individuals must spend at least 80 percent of premium revenues on health care. If they fail to meet those targets, companies must distribute rebates to their policyholders.

Traditionally, the MLR has been a very simple formula: dollars paid out in claims over dollars collected in premiums. Until enactment of the ACA, that formula has not included as part of “claims” insurers’ expenses for activities that could improve health care quality. Such activities can include, for example, investments in health IT infrastructure in clinical settings, quality reporting systems, and care management programs. However, the ACA specifies that insurers’ investments in these areas can count toward medical spending and should not be considered administrative expenses.<sup>9</sup> This change to the traditional definition of the MLR likely reflects Congress’ interest in ensuring that companies continue to make investments in quality improvement and aren’t penalized for doing so under the MLR formula.<sup>10</sup>

### Transparency

The ACA further tries to encourage insurers to maintain and even expand quality and delivery system initiatives by instituting new reporting requirements for health insurers regarding the benefits, structures, and activities designed to improve the quality of care.<sup>11</sup> Specifically, the law requires all health plans, including self-insured group plans, to report to the U.S. Department of Health and Human Services (HHS) and to their enrollees on how their benefit designs, structures, or provider reimbursement structures are:

- Improving health outcomes through quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives (including through the use of medical homes);
- Preventing hospital readmissions through a comprehensive program for hospital discharge that includes patient education and counseling, discharge planning, and post-discharge reinforcement by an appropriate health professional;
- Improving patient safety and reducing medical errors through the appropriate use of best clinical practices, evidence-based medicine and health IT; and
- Implementing wellness and health promotion activities.<sup>12</sup> HHS is required to develop standards for health plans to report this information by March 23, 2012, and make any such reports available through a publicly accessible website.

In addition, the ACA requires all plans, including self-insured group plans, to submit to HHS information that relates to plan quality, cost of coverage, and enrollee satisfaction. Plans must submit this information to HHS and the state insurance commissioner, and make it available to the public.<sup>13</sup> The required disclosures include information related to:

- Claims payment policies and practices;
- Periodic financial disclosures;
- Data on enrollment and disenrollment;
- Data on the number of claims that are denied;
- Data on rating practices;
- Information on cost sharing and payments with respect to any out-of-network coverage;
- Information on implementation of new patient rights under the ACA; and
- Any other information HHS determines appropriate.

These new transparency and quality reporting requirements apply to all health plans, and ACA sets up a similar transparency and reporting structure for health plans participating in state insurance exchanges.

### Certification Requirements for Plans in Health Insurance Exchanges

Under the ACA, health insurers wishing to offer plans through insurance exchanges must satisfy minimum federal standards. To be qualified, they must not only provide the federally prescribed essential benefits package<sup>14</sup> and offer products that meet minimum cost-sharing and actuarial value targets, they must be certified according to specified criteria.<sup>15</sup> Four of the nine statutory criteria highlight the importance that the ACA places on plans' efforts to improve clinical quality and care delivery:

- **Accreditation.** The law requires all participating insurers to be accredited based on clinical quality measures and patient experience ratings. Such accreditation must be based on the companies' local performance on clinical quality measures such as the Healthcare Effectiveness Data and Information Set (HEDIS®), patient experience ratings via a standardized survey (the Consumer Assessment of Healthcare Providers and Systems survey, or CAHPS®), as well as consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs.
- **Quality Improvement.** Participating plans must implement a quality improvement strategy that includes provider-level quality reporting, case management, care coordination, prevention of hospital readmissions, activities to improve patient safety, and activities to reduce health disparities. As discussed above, all plans, whether or not they participate in an exchange, must report to HHS regarding their efforts to implement these activities.<sup>16</sup>
- **Transparency.** Participating plans must provide to enrollees and prospective enrollees information on their performance on quality metrics that have been endorsed through a stakeholder consensus process.
- **Pediatric quality.** Participating plans must report at least annually to HHS on their performance on clinical quality measures developed for pediatric care in the Medicaid and CHIP.<sup>17</sup>

In addition, in order to allow consumers and small business owners to effectively compare the relative quality and value of participating health plans, the law requires HHS to develop a rating methodology based on relative

price and quality. Exchanges must provide consumers with those plan ratings on their web portals.<sup>18</sup>

HHS has put forth initial guidance for state exchanges on the implementation of these quality-related criteria, and the agency has indicated that a later rule will provide additional detail.<sup>19</sup> The agency proposes that exchanges

must, at a minimum, collect and evaluate plans' reports on their quality improvement strategies and oversee assessments and ratings of plans' health care quality and patient outcomes.<sup>20</sup> The proposed rule also provides exchanges with the discretion to go beyond the federal minimum and set additional certification criteria relating to quality improvement and efficiency.<sup>21</sup>

## Using an Exchange to Advance Quality Improvement: Options for States

Both the intent and the requirements of the ACA make exchanges a logical extension of quality improvement work. As marketplaces for consumers and small businesses to compare plans on cost and quality, exchanges can organize that market in a manner that builds in incentives and requirements for plans and providers to improve quality. However, many of the potential functions discussed here presume that the exchange has sufficient authority to engage in performance-based contracting with health plans or otherwise exercise discretion regarding a plan's participation in the exchange.<sup>22</sup> A state that designs its exchange to be a passive "Yellow Pages" of health plans would significantly curtail an exchange's ability to be a catalyst for quality improvement or delivery system reform efforts.

### Contracting for Quality

Exchanges can set quality standards for plans beyond those required by the ACA. This could mean establishing clear criteria that all plans must meet in order to participate. It could also involve performance-based contracting with individual plans, in which the exchange uses a request for proposal (RFP) process to encourage plans to submit bids that include key quality and delivery system improvement components. For example, exchanges can require plans to use providers that are recognized as patient-centered medical homes (PCMH),<sup>23</sup> or encourage them to use a common set of performance metrics and quality-based reimbursement incentives. As one employer-purchaser noted, "We look at exchanges as a mechanism to be a driver for health care transformation. We would be supportive of building into plan requirements that they not just meet very low thresholds... Maybe plans could be given an advantage in the exchange if they can show

they're driving quality improvement, value-based benefit design, delivery system reform."<sup>24</sup>

This kind of contracting can also begin to align quality improvement and reimbursement strategies across health plans, so they are sending a common set of signals to their provider networks. "At the provider level, clearly they want to receive one signal from plans on what's important to measure and improve, not multiple different signals. That doesn't mean identical contracts [between plans and providers], but to the extent that, for example, breast cancer screening is measured, it is defined one way for all plans, not multiple ways," said one quality expert.<sup>25</sup>

Large employers and employer-purchasing coalitions have recognized this and have begun to collaborate on purchasing priorities for health plans. For example, eValu8, developed by the National Business Coalition on Health (NBCH) and used by its member employers and employer-purchasing coalitions, is a tool that allows purchasers to evaluate health plans on criteria such as cost control, quality, transparency, evidence-based care, and other factors. NBCH's CEO describes the benefits of eValu8 this way: "Setting expectations, demanding performance but also creating partnerships: just having one plan in a market doing something isn't going to send sufficient signals to providers."<sup>26</sup>

Plans can also benefit from having a partner in their effort to require participating providers to meet quality standards. Said one plan representative of its work with a major state purchaser, "For those of us who are negotiating with providers, we might like to see an exchange putting requirements on plans that give us leverage in those negotiations."<sup>27</sup>

Indeed, exchanges hold the potential to boost what are now disparate and largely isolated efforts, both public and private, to use reporting and payment to drive improvements in quality and cost of care. As another representative of large employers noted hopefully, “I think it could be a tipping point, particularly if exchanges have the same kind of purchasing strategies as state employees, Medicaid programs and private purchasers, and they’re all demanding the same measures, requiring the same level of transparency and expecting the same provider payment mechanisms. It might be a point at which you get enough market influence. No one of them can do it alone.”<sup>28</sup>

A private-sector purchasing initiative in Washington provides a model for states wishing to implement this kind of multi-payer quality improvement and delivery system reform. The Puget Sound Health Alliance, founded in 2004, covers a five-county region and includes more than 150 public- and private-sector employers, union trusts, hospitals and physician groups, government agencies, pharmaceutical companies, and others. Members include Boeing, Starbucks and the Washington State Health Care Authority, which administers the state’s Basic Health Plan and public employee plans. The Alliance uses NBCH’s eValu8 tool to set expectations for health plans and providers, and publishes a report card that evaluates and compares the performance of hospitals, clinics, and medical groups in the Puget Sound region on measures of quality and appropriateness of care, with a goal of having all local providers in the top 10 percent in performance nationally.<sup>29</sup> Since 2006, the Alliance has also been part of the Aligning Forces for Quality program, an initiative of the Robert Wood Johnson Foundation that supports collaboration among health care providers, payers, plans, and consumers in 17 communities across the United States.<sup>30</sup> Given the breadth of support and history of successful quality improvement efforts in Washington, it is little wonder that state officials are keeping their sights on the potential for their exchange to play a role in the work already underway. In their grant proposal to HHS to support planning and establishment for their exchange, the state indicates plans to develop a quality rating system designed to benefit from the lessons learned from the Puget Sound Health Alliance’s efforts to collect and disseminate quality data.<sup>31</sup>

### Aligning with Other Purchasers

In many states, exchanges will represent a relatively small portion of the total commercial insurance market.<sup>32</sup> For exchanges to play a significant role in driving delivery system reform, they will likely need to align purchasing goals and requirements with those of other purchasers, public and private. Exchanges might undertake this initiative for two reasons. First, exchanges will be the portal for not only individuals and small businesses enrolled in private plans, they will also be a portal for individuals and families enrolling in Medicaid or CHIP. And, as noted above, significant percentages of those individuals will move between Medicaid, exchange coverage, and employer-sponsored coverage over time. The state thus has a significant incentive to set population-level goals for health outcomes, encourage public- and private-sector purchasers to set common benchmarks and standards, and agree on the types and levels of incentives that will help plans, providers, and consumers reach those goals. As one former Medicaid agency head noted, “In most states, twice as many individuals will be eligible for Medicaid as will be eligible for the qualified health plans in the exchange, so we squander an opportunity if we do not approach it that way.”<sup>33</sup>

For example, New York early on recognized the need for a multi-payer approach to improve primary care through the development of PCMHs. Historically, delivery system reform initiatives, like PCMH, have been limited by their small size. Providers typically have patients covered by many plans, so it is rarely in their interests to transform a practice or hospital to respond to the demands of a single health plan or payer. To launch the Adirondack Medical Home Demonstration (AMHD), the state successfully brought together nearly all payers in the region to agree on a uniform set of standards for participating primary care practices. The payers also agreed to reimburse those practices \$7 per member per month to cover the costs of the additional services associated with PCMHs. The state played several different roles to support the demonstration: as payer under Medicaid, as employer and purchaser for state employees, as a regulator, public health agency, and the lead agency for state health policy.<sup>34</sup>

Similarly, in planning for its exchange, Oregon officials have been considering ways to promote an alignment of strategies across state health purchasers. The state has a long history of health reforms that include a focus on

provider-level quality improvement and delivery system reform. The Oregon Health Care Authority was created by the legislature two years ago and launched on July 1, 2011, with a goal of bridging silos for state health care purchasing strategies. For example, the state is embarking on an effort to redesign care delivery in its Medicaid program by creating “Coordinated Care Organizations” to better manage beneficiaries’ chronic health needs while reducing costs. State officials note that their aim is also to include the public employee and Oregon educator boards in the program. While their exchange will be housed outside the Authority in a public-private corporation, state officials indicate that they will keep their sights on ensuring that the exchange does not become its own silo. “A lot of the planning is how to keep development of the exchange and products aligned with initiatives in the Health Authority,” noted one state official. “The exchange is one of many tools to align what the state is doing with respect to quality improvement and health reform.”<sup>35</sup>

A second reason for exchanges to consider partnering with other payers on purchasing for quality is to expand the number of data sources and improve the reliability of results, which in turn can help engender greater confidence and buy-in from providers and consumers. Many initiatives that report on the performance of individual providers, particularly at a clinic or physician-office level, are hindered by the problem of small sample sizes. In other words, for any given practice, the number of patients covered by a particular insurer may be fairly small, particularly for condition-specific measures (i.e., those related to the treatment of diabetic, heart disease, or breast cancer patients). Those small sample sizes make it difficult to generate reliable and credible quality reports. To the extent that exchanges can expand the number of payers participating in quality-related data collection and reporting initiatives, they can help play a role in improving the reliability of the data upon which provider and plan performance is assessed and compensated.

For states that want to align the purchasing strategy of their exchange with that of other purchasers, one major undertaking is to agree with those purchasers on a set of goals and performance measures that will be the bases for contracting. This core set of agreed-upon goals and metrics achieves three primary purposes: First, the process of agreeing upon common goals for health outcomes, quality, and efficiency allows all participants in the system

to focus on the state’s top health priorities, and avoid the distractions of disparate and potentially conflicting agendas. Second, setting a core set of metrics – and agreeing to use the same terms and definitions – can help generate greater buy-in from physicians, hospitals, and other providers who are frequently frustrated by the number and diversity of performance metrics upon which they are required to report, and based upon which they may be judged and compensated. Finally, using the same metrics facilitates providing consumers with comparable information across programs.

### **Promoting Quality through Web-Based Information and Decision Tools**

Whether or not the exchange is “active” or “passive” in its relations with health plans, the ACA requires exchanges to give consumers web-based comparative information that includes: quality ratings, enrollee satisfaction surveys, and a calculator to compute out-of-pocket costs, in addition to summaries of benefits and other plan information.

Exchanges could go further, and provide plan performance information on specific quality metrics important to consumers, so that they can more easily assess which plans do better at what they want (i.e., prevention, care coordination, diabetes care), and avoid plans that score poorly. The exchange web portal could also build the capacity to provide consumers with provider-specific performance information. For example, Minnesota is considering making information collected under a state quality improvement initiative available to shoppers in the exchange. In 2008, the state enacted bipartisan health reform legislation that requires the development of tools to promote health care value – reflecting both cost and quality of care. As part of that effort, the state has developed a “provider peer grouping” system that will compare physician clinics and hospitals based on a measure that combines risk-adjusted cost and quality for each provider.<sup>36</sup> The state requires employers and health plans to use the system in developing products, so state officials see the exchange as a logical way to extend the program’s reach.<sup>37</sup>

To the extent exchanges want to use quality information to encourage consumers to make more value-oriented choices, they will need to “meet people where they’re at,” as one expert in health plan quality put it.<sup>38</sup> Most consumers today don’t currently make health plan choices based on

quality ratings – they are more interested in the price of the product, and often, whether a personal physician is included in the plan network. According to one expert, “[m]any consumers do not believe plans are responsible for anything other than paying for their care and granting them access to the providers they want to see.”<sup>39</sup> Further, most consumers simply do not want to spend a lot of time and effort researching, comparing, and shopping for health insurance.<sup>40</sup> They want a process that is simple and quick. Therefore, exchanges may wish to use web-based, plan-chooser software to help sort health plans based on

performance as well as deploy iconography, pop-up boxes, and other tools that could make it easier for consumers to take quality into account as they compare plans. Exchanges could go further and use web-based tools to feature top-rated plans in ways that make it more likely people will choose those plans. One expert also suggested building education on quality into the functions of exchange Navigators.<sup>41</sup> Regardless of how exchanges deploy the information, any efforts to integrate quality data into the purchasing experience will need be sensitive to the cognitive and time demands placed on consumers.

## Implementing a Quality Improvement Strategy: Issues to Consider

In spite of the premium placed by the ACA on quality improvement, we found only a handful of states tackling these issues in the context of their exchange. Fewer still are thinking about going beyond the ACA requirements for exchanges in order to catalyze state-wide quality and delivery system reforms. The states that are taking on these issues tend to be those that have had a longstanding focus on promoting quality and value in their state’s health care delivery system, and they tend to see exchanges as one additional tool to help achieve their goals. For example, because Minnesota has had a community of stakeholders – providers, policymakers, consumers, and health plans – working on quality improvement for many years, a state official noted to us that “putting the exchange together with [those initiatives] makes sense.”<sup>42</sup>

While such states recognize that tackling the quality and efficiency problems in our health care system is critical, they also know that the first priority of their exchange is to attract health plans and enrollees. In other words, as much as some state exchange officials might like to focus on quality improvement and delivery system reform, they have more fundamental tasks to complete first. They must ensure their exchange meets the minimum federal requirements, offers an attractive and competitively priced selection of products, and draws in a sufficient number of enrollees to be sustainable. As a Maryland official noted, the state has “a number of [quality] efforts already ongoing, so we shouldn’t see the exchange in isolation.

But the fundamental challenge for the exchange is making sure enough people get in there. We need to avoid [the exchange] becoming a high-risk pool. These need to be the priorities.”<sup>43</sup> Similarly, the officials in Washington explained, “We are so focused on what it takes to get this thing up and running in 2014.... We are conscious of the opportunities for quality improvement and delivery system reform, but it’s not our primary focus for 2014.”<sup>44</sup>

In addition, as states plan and implement their exchanges, they must work to get and maintain the support and cooperation of a diverse set of stakeholders. Adding delivery system reform to the exchange planning process may destabilize or even undermine those efforts, depending on how various stakeholders view their role in delivery system reform. “If stakeholders aren’t at the table [for exchange planning and implementation], we won’t even have an opportunity to do quality improvement and delivery system reform,” noted one Washington state policymaker.<sup>45</sup>

### Coordination: Easier Said Than Done

While aligning the exchange’s purchasing strategy with that of other state or private purchasers could help engender broader quality and delivery system reforms, doing so is not without administrative challenges. Experts we interviewed noted that getting different purchasers to coordinate and agree on common goals and measures is no small feat.

And while there are public-private purchasing coalitions that have achieved success aligning goals and measures, they are often very particular to the locale in which they

operate and often are a result of one or two individuals' drive and leadership. One large employer representative noted, "Community-based alliance building is a messy business; you're part of a group dynamic and giving up a measure of control."<sup>46</sup>

Even aligning purchasing across state purchasing agencies can be complicated. Such an effort requires communication and collaboration across agencies (i.e., state employees, Medicaid, CHIP) that may not have historically worked together and may have very different constituencies, provider networks, contracting traditions, and legal structures. For example, in Massachusetts, the state employee benefits purchasing agency (the Group Insurance Commission) makes effective use of performance-based contracting with plans to encourage greater quality and efficiency among participating plans and providers. However, to date there has been few concerted efforts to align its contract provisions with those of the Massachusetts' exchange (the "Connector"). However, the head of the Group Insurance Commission notes that it is "kind of slouching toward conformity...I really don't want to do absolutely identical RFPs, and absolutely identical measures, and absolutely identical procedures. If we do it, there's going to have to be some compromise about how 'stiff' those measures are going to be."<sup>47</sup>

Yet if the exchange is not aligned with other large state purchasers, it could limit its leverage with plans and providers. And to the extent it conflicts with or is separated from the contracting strategies of other state purchasers, it could undermine existing efforts in the state. From the perspective of at least one health plan representative, "the only way [the exchange] can be advantageous is if it produces less overlap and duplication in the marketplace."<sup>48</sup>

As the Massachusetts experience shows, many state officials recognize that agreement on measures and incentives can start small and evolve over time. States can start with a core set of goals and measures, perhaps defined by the federal government, and then allow for additions at the state's discretion. As one expert put it, states should "build on what's already out there.... Don't create a new thing that everyone has to get their head around."<sup>49</sup> Once a core set of measures is in place, many states will want to ensure that additional goals and standards reflect local priorities for public health, transparency, and cost containment. For example,

Washington state officials are interested in measuring generic drug utilization.<sup>50</sup> Rhode Island has had a particular interest in tracking provider performance in screening all age-appropriate children for lead poisoning.<sup>51</sup>

Experts offered two more cautions: Quality measurement should be viewed as an evolving process that cannot start with unrealistic expectations for plans and providers. "It's critical to recognize what measures are feasible to implement today with acceptable burden and define the pathway for when additional, more compelling measures could be included. You could think of it as the initial stage of performance measurement and how to build from there based on need and health information technology capacity."<sup>52</sup>

Finally, it's imperative that exchanges adopt a quality measurement approach that garners confidence from those being measured. Of the measurement process, a health plan representative noted: "The challenge is having a robust process behind it, trusted by the people using it. In my experience, if the process itself appears to be arbitrary and there aren't good ways of judging, you get a lot of pushback from plans, and it's probably reasonable to push back... You need a robust, evidence-based and trusted process."<sup>53</sup> The same kind of trust in the process will be necessary for providers, to the extent the exchange intends to get involved in any provider-level quality reporting and improvement. Perhaps equally important is the need to have the confidence of consumers who will use the measures to choose their plan and provider.

### **Avoiding Unnecessary Roadblocks**

While some states may not want their exchanges to undertake quality improvement efforts beyond what the ACA requires, there are steps they can take now to at least allow for a broader quality improvement agenda in the future, once an exchange is established and growing in enrollment. First and foremost, state legislatures, policymakers, and exchange planners should be cautious about imposing limits on exchange authority that could unintentionally limit its ability to engage in quality improvement efforts. Statutory or regulatory language to prohibit an exchange from being an 'active purchaser' may address some political concerns relating to the role of the exchange, but it may also preclude the ability of the exchange to use performance-based contracting with plans and other tools to make higher-value products available to individuals and small businesses.

In addition, states can build in structures and mechanisms now so that their exchange can help extend quality improvement efforts and become another voice among payers, purchasers, and policymakers pressing for change. For example, states could include quality experts from other state programs, including Medicaid and the state employee benefit program, in exchange planning and on exchange governing boards, to bring their expertise in quality improvement initiatives to the discussion on key issues, such as the necessary informational infrastructure, contracting policy, and standards for participating plans. Their presence might also help avoid conflict in the expectations and requirements the exchange and state agencies might place on health plans and providers.

States must also ensure that exchanges have sufficient financial resources to develop and sustain quality improvement initiatives. While states can and should attempt to leverage federal exchange establishment grants to support a quality improvement infrastructure (i.e., necessary IT, data collection and reporting mechanisms, and experienced leadership and staff), they must also develop an ongoing source of revenue in order to effectively implement a quality improvement agenda.

### Generating Community Support

Lessons learned from other efforts suggest states will need broad public support and strong leadership to use exchanges to help drive the health care delivery and financing changes needed to improve quality. Some quality experts suggest this could be generated by a state-level health care quality council that could bring diverse and essential players to the table to develop a common understanding of what the state of quality is in a geographic area, as well as strategies and mechanisms for addressing quality. The council could be a public

forum to help generate buy-in for the quality goals and methods an exchange might adopt.<sup>54</sup> For example, in 2011, Maryland's governor created by executive order the Maryland Health Quality and Cost Council to coordinate quality and cost initiatives among various entities, including health insurance exchanges, and to identify replicable best practices for quality improvement and cost containment.

Experience with other efforts suggests local leadership will be essential. Many payers and private-sector purchasers may be reluctant to engage because the return on investment for quality improvement efforts is uncertain or long-term. But with sufficient leadership and market leverage, these stakeholders can often be brought to the table. For example, the creation and success of the Puget Sound Health Alliance is largely credited to the leadership and personal outreach of former King County Executive Ron Sims. His one-on-one persuasion of CEOs and other senior executives resulted in broad buy-in from the business community, and within two years, the participation of every health plan in Washington.<sup>55</sup> Similarly, the Adirondack Medical Home Demonstration depended heavily on strong leadership from senior state officials, who worked hard to persuade reluctant health plans to participate.<sup>56</sup>

For exchanges to succeed in driving quality improvement among participating health plans and providers, it will require a considerable investment of leadership, as well as a sophisticated IT infrastructure and experienced staff. Because the ACA places such primacy on quality improvement and delivery system reforms in public programs, many states may justifiably look for appropriate support from the federal government as they work to extend these reforms to the private sector through insurance exchanges.

## Federal Role in Promoting Quality through Insurance Exchanges

To be sure, states will have the primary responsibility for setting priorities, goals, benchmarks and incentives for quality improvement. However, these efforts can be complemented, and supported, by the federal government.

The federal government is by far the largest single health care purchaser in the country. Through Medicare,

Medicaid, CHIP, military health care (TRICARE), veteran's health care, and the Indian Health Service, federal programs provide or subsidize coverage for approximately 93 million people.<sup>57</sup> Through the federal premium subsidies and Medicaid expansion authorized by the ACA, this number is expected to expand by

an additional 34 million people.<sup>58</sup> No one entity has a greater stake in a reformed health care system that delivers higher-quality, more affordable care than the federal government.

In the wake of evidence that Americans receive poor quality care roughly half the time they receive treatment, combined with estimates that up to 40 percent of federal expenditures on health care are wasted on inadequate or inappropriate care, the federal government has begun to use its purchasing power to encourage the delivery of higher-quality, more efficient care.<sup>59</sup> The Centers for Medicare and Medicaid Services (CMS), in particular, have begun to test efforts to move Medicare from a passive payer of claims to an active purchaser of health care goods and services. It has also begun to join with Medicaid and private sector purchasers to establish a consistent set of incentives for providers to coordinate and better manage the care of patients with chronic conditions.<sup>60</sup> The ACA expands on this movement through demonstration projects and programs that encourage a shift away from fee-for-service payments to quality- and outcomes-based payments, such as value-based purchasing for hospital services in Medicare, supporting patient-centered medical home initiatives in Medicare and Medicaid, and testing the feasibility of accountable care organizations (ACOs).

While the federal government is not the direct purchaser of insurance sold through exchanges, they have “skin in the game” because of the premium and cost-sharing subsidies, the cost of which is exclusively borne by federal taxpayers. It will thus be important for HHS/CMS to explore ways to help improve the value of the product that taxpayers are subsidizing, both through rules for insurance exchanges and in the agencies’ efforts to drive quality in programs like Medicare and Medicaid.

### Federal Establishment Grants

As states undertake the process of building the infrastructure necessary to establish an exchange, the ACA authorizes HHS to support those efforts through grants to states.<sup>61</sup> HHS awarded a first round of planning grants in 2010, and expanded its financial support early in 2011 through a “Funding Opportunity Announcement,” (FOA) describing the availability of one-year (Level I) or multi-year (Level II) establishment grants for states meeting certain benchmarks.<sup>62</sup> These grants are available

to support exchanges through 2014. Beginning in 2015, exchanges must be self-sustaining.

The FOA delineates 11 core areas in which a state must show progress in order to establish an ACA-compliant exchange, including governance, IT systems, financial management, market reforms, and integration with other key state agencies such as Medicaid and the Insurance Department. With the exception of a reference to the ACA-required quality rating system for participating health plans, the FOA doesn’t mention the exchanges’ role in quality improvement or delivery system reform. Given the effort it will take many states just to show progress in the 11 core areas, it would be a stretch to suggest that the FOA include those areas as “core” to receiving federal grant monies.

However, for states that want their exchange to play a role in quality improvement, there are considerable infrastructure and resource demands. It will take a modern data infrastructure to support reporting and sharing of quality metrics, as well as considerable human capital to develop a core set of metrics, coordinate with state and private-sector purchasers, and conduct the necessary stakeholder outreach. HHS could encourage states to build some of those costs into their exchange establishment grant proposals. Washington has done so with its Level I grant application, in which they included a request for funds to support the integration of delivery system reform with exchange development and design.<sup>63</sup>

In addition, an increasing number of states are building all-payer claims databases (APCD) to advance quality improvement efforts and better understand the utilization and costs of health care services in the state.<sup>64</sup> While these databases have been conceived and built independently of insurance exchanges, their existence holds benefits for the exchanges, not just for collecting and reporting on critical access, quality and cost data, but also to help support the ACA-mandated state risk adjustment programs for health plans.<sup>65</sup> HHS’ proposed regulations for the insurance exchanges indicate that the implementation of a state risk adjustment program is a top priority.<sup>66</sup> This redistribution of funds will be applied across health plans for the small group and individual markets, both inside and outside the insurance exchanges. To work effectively, state risk adjustment programs will require the development and use of a robust commercial health insurance claims database. States with APCDs in place by January 2013 will be permitted to use them to meet the data collection

requirements for the risk adjustment program. In fact, HHS had indicated that states with APCDs will be better positioned to meet the necessary data collection standards.<sup>67</sup> Thus, APCDs can not only help states run an effective risk-adjustment program, exchanges can use them to help support any efforts to collect and report on health plan and provider-level quality, efficiency, and other performance measures. However, developing the infrastructure for APCDs has presented a fiscal challenge for cash-strapped states. HHS could support the development of the infrastructure for risk adjustment as well as exchange operations by allowing states to request funds in their federal exchange grant proposals to build and use APCDs for these purposes.

### **Incorporating Exchanges into the National Quality Strategy**

HHS could also consider ways in which exchanges could be used to advance the nation's National Quality Strategy. The ACA requires HHS to establish a "National Strategy for Quality Improvement in Health Care" (the National Quality Strategy). In it, HHS must set priorities for the federal government's quality improvement efforts, and draft a strategic plan for achieving those priorities.<sup>68</sup> The Department released its initial strategy and plan for implementation in March 2011. In it, the agency emphasizes the importance of communities and states as laboratories for improving quality and controlling costs, and highlights exchanges as one mechanism for improving health care quality by "providing transparent information for consumers and by creating quality standards for health plans."<sup>69</sup>

The National Quality Strategy could go further, however, and explore ways in which the federal government can leverage state-based exchanges, so that consumers and beneficiaries receive consistent information about health plan quality across all programs, public and private. For example, CMS could work with state exchanges to ensure that plans' performance across the public and private markets is judged based on the same core set of metrics, and any incentives for high-quality performance (i.e., bonus payments, enhanced placement on web portals, or access to default enrollees) are implemented consistently across programs.

In addition, HHS could use the process of developing and refining the National Quality Strategy to assess whether

existing federal-state or public-private partnerships to improve quality could include insurance exchanges, once they are established. For example, CMS programs providing financial incentives for states to improve quality for Medicaid beneficiaries could encourage those states to align strategies with their exchange. Similarly, federal efforts to partner Medicare with state and local multi-payer medical home programs could promote the inclusion of plans participating in state exchanges.

### **Building on Medicare Advantage**

CMS' experience with the Medicare Advantage (MA) program, and its efforts over the last decade to improve health plan quality, could also be an important source of support for state exchanges. The MA program, also called Medicare Part C, allows beneficiaries to receive their Medicare benefits through private health plans. CMS has taken some innovative first steps towards using its purchasing power in Medicare Advantage to promote quality improvement and delivery system reform among participating plans. For example, it has issued guidance to carriers in MA indicating that they are expected to use "integrated health plan approaches such as disease prevention, disease management, and other care coordination techniques."<sup>70</sup> CMS also reserves the right to terminate or refuse to renew plans that "fail to implement an acceptable quality improvement program."<sup>71</sup>

Furthermore, beginning in 2008, CMS launched a star rating program for participating health plans, with five stars denoting the highest-quality plans.<sup>72</sup> These ratings are made available to beneficiaries comparing their health plan choices on [medicare.gov](http://medicare.gov), as well as through other program materials. The ratings reflect a combination of HEDIS® and CAHPS® scores, as well as performance on selected measures for Medicare Prescription Drug plans, the number of enrollee complaints, health outcomes, and plan audits.<sup>73</sup> Beneficiaries can see overall star levels, "domain" star levels (i.e., performance on managing chronic conditions), and results on individual measures.<sup>74</sup> The site also compares CAHPS® scores between MA plans and traditional fee-for-service plans. In addition, the lowest-performing plans are tagged with a warning label that says, "Low Performing Plan." However, as of November 2010, nearly half of all MA enrollees were in plans with three or fewer stars.<sup>75</sup> What is not clear is why beneficiaries choose or remain in plans with low quality ratings, and it may be too soon to say whether the

star rating program will encourage more beneficiaries to choose higher-quality plans.

Under the ACA, the star rating system will take on more import, as plans' MA payments will soon be linked to their star rating. Sometimes called plan "pay for performance" or "P4P," CMS recently announced a demonstration project in which plans with three or more stars will receive bonus payments; those with fewer stars will not. The bonus payment increases with each additional star.<sup>76</sup> In addition, five-star plans will be permitted to market their plans and enroll beneficiaries outside of annual open enrollment periods.

In a similar vein, the ACA requires state insurance exchanges to implement a rating system for health plans based on their relative quality and price.<sup>77</sup> To help ensure consistency across programs, HHS could build on the metrics and methodology CMS uses for quality ratings in the MA program. However, HHS will likely need to make adjustments to reflect "price" as required by the statute, as well as the fact that exchange plans will serve a younger population. Having the ratings in MA and in exchanges centered on a core set of measures (and, ideally, consistent with the goals of the National Quality Strategy) can help align quality incentives for payers, provide consumers with information that is consistent across programs, and help providers with a more streamlined, uniform set of incentives.

State insurance exchanges are not required to establish a bonus or P4P program for highly rated plans. To do so under current law, they would need to establish a separate state fund with which to pay bonuses. However, because consumer and small business purchasers are primarily motivated by the price of their plan, HHS, possibly through the new Center for Medicare and Medicaid Innovation (CMMI), could explore ways in which consumers could garner a financial benefit for choosing a plan based on quality in addition to price. For example, commentators have suggested a reallocation of funds among plans, similar to the risk-adjustment process, which could allow higher-quality plans to lower premiums for enrollees. Others have suggested CMMI can play a role expanding our understanding of how to promote informed consumer choice through web portal decision support tools.<sup>78</sup> Exchanges could also deploy other incentives used in the MA program, such as allowing highly-rated plans to market their products outside open enrollment periods or terminating plans that fail to implement a

quality improvement program. At a minimum, CMS can share best practices and lessons learned from quality improvement efforts in MA with state exchange personnel.

### **Creating Complementary Incentives through the Federal Web Portal ([healthcare.gov](http://healthcare.gov))**

The ACA directs HHS to establish a web portal at [healthcare.gov](http://healthcare.gov) to provide information on health coverage options to consumers and small business owners.<sup>79</sup> The first version of the site was launched July 1, 2010, and HHS has continued to add new features. For the first time, the site provides a centralized, accessible source for comparative information on health plans that had previously been widely scattered and difficult to compare.

States that establish exchanges are required to develop a similar web portal for the exchange that will help consumers shop for and compare plans within the exchange.<sup>80</sup> At the same time, the ACA requires HHS to continue to maintain and update [healthcare.gov](http://healthcare.gov).<sup>81</sup> Thus, while it appears that states will have web portals to allow consumers to assess and compare plans in their exchanges, the HHS portal will likely provide consumers and small business owners with information on plans offering coverage outside the exchanges.

For [healthcare.gov](http://healthcare.gov), HHS currently collects data from plans on benefits and rates, allowing consumers to compare plans by evaluating standard costs and benefits associated with each. Consumers can search for plans based on premiums, out-of-pocket limits, deductibles, type of plan (i.e., HMO vs. PPO), and benefits (i.e., whether the plan covers prescription drugs or maternity services). However, there is very little information for consumers regarding plan quality. For example, the site does not provide information on whether a plan is accredited by a national accrediting body, and plans are not rated based on quality or price. Consumers also cannot get more specific information on plans, such as scores on HEDIS® or CAHPS® measures, numbers of complaints, denied claims, or the plan's policies on in-network and out-of-network care.

HHS will, however, soon be collecting this information under two important provisions of the ACA. The law requires all health plans, whether or not they participate in exchanges, to submit financial, enrollment, and quality information to HHS.<sup>82</sup> In particular, plans must submit reports to HHS on benefits or reimbursement structures

that will improve health outcomes through better care management and coordination, activities to prevent hospital readmissions, activities to improve patient safety, and efforts to promote health and wellness. The law includes a similar reporting provision for qualified health plans to be certified in state exchanges, with two key additions.<sup>83</sup> Specifically, qualified health plans must not only report on what they're doing related to quality improvement activities, they must actually "implement a quality improvement strategy."<sup>84</sup> They must also report on their activities to reduce health care disparities. HHS could ensure that the information they collect is provided to consumers on healthcare.gov, using language, iconography, and formatting to ensure that it is understandable and useful for making informed comparisons among health plans. In addition, HHS will need to work to ensure that the ACA's requirement that plans report quality data to the federal government is consistent and aligned with the similar set of requirements that state exchanges collect this data.

### **Preserving State Flexibility with the Multi-State Plan Program**

The ACA authorizes a new, "multi-state plan" (MSP) program in an attempt to inject greater competition into states' individual and small group insurance markets.<sup>85</sup> The program will run under the auspices of the U.S. Office of Personnel Management (OPM), which runs the health benefits program for federal employees (FEHBP). Depending on the program design, the standards OPM uses to certify MSPs could have significant implications for state efforts to encourage quality improvement among insurers.

Under the law, OPM is required to enter into contracts with health plan issuers so that there are two or more MSPs in each state. OPM is required to approach the contracting process in a manner similar to the process it engages in with plans in FEHBP. Not all issuers will be eligible. In the first year, the issuer must be able to offer a plan in 60 percent of the states, with the ability to be in all states by the fourth year of the program.<sup>86</sup> While smaller, regional issuers are allowed to join together to apply to be an MSP, it is likely that only the largest national carriers will have the capacity to apply, at least in the early years of the program.

The advantage of the MSP program for issuers is that once OPM certifies that their plan meets the MSP standards, it is "deemed" eligible for participation in all state exchanges.<sup>87</sup> While MSPs must meet all the minimum federal standards for plans to participate in an exchange, proposed federal rules would bar a state exchange from imposing on them any additional certification requirements.<sup>88</sup> This prohibition could have significant implications for the efforts of state exchanges to engage plans in quality improvement and delivery system reform efforts. If MSPs are exempted from an exchange's quality improvement initiatives, it will be difficult for the exchanges to require their competitors to participate. Imposing requirements on some plans, but not others, can result in an unlevel playing field that insurers will strongly resist. Perhaps in response to insurers' concerns about these issues, Congress included a separate provision in the ACA exempting all insurers from a state's quality improvement and reporting requirements if OPM allows MSPs to be exempted from them.<sup>89</sup> Thus, for states and state exchanges to successfully implement quality improvement and delivery system reform initiatives with health plans as partners, it will be important for OPM to ensure that MSPs fully participate in these state programs.

## Conclusion

In exploring the opportunities for states to use their exchanges to help drive quality improvement and delivery system reform, we found several opportunities for states to go beyond the ACA's minimum requirements for exchange plan certification and web-based comparative information on quality ratings and enrollee satisfaction. States that have historically been leaders in quality improvement efforts are logical places

for that work and exchange planning to be joined—to amplify existing state efforts and make higher-value health plans available to exchange enrollees. But the number one task before states is to set up an exchange that meets the minimum federal standards in a relatively tight timeframe. Even those that would like to undertake delivery system reforms within their exchange consider it a longer-term goal.

Thus, a few lessons emerge from our analysis. First, many of the potential functions an exchange may undertake to improve quality assume some level of authority and discretion on the part of the exchange to engage in performance-based contracting and negotiate with health plans. However, given the relatively small share of the total commercial market most exchanges will have, perhaps the most successful approach is to align exchange purchasing goals and requirements with those of other purchasers, public and private.

Second, states can lay the groundwork now to allow for an exchange to undertake quality improvement efforts in the future. That groundwork can range from simply including quality experts from related state agencies in exchange planning work, in order to avoid sending conflicting signals to plans and providers, to more formalized efforts to coordinate quality improvement efforts. But any

attempt to precluding an exchange to negotiate with plans or exercise independent discretion regarding the interests of its enrollees, may cut off many of the tools an exchange may have to improve quality.

Third, quality improvement is understandably not an up-front priority for exchange planners, and it may be more successfully pursued after an exchange has been operational for a few years, when enrollment is sufficient for the exchange to exercise more market leverage.

Finally, given the federal “skin in the game” with federally-funded premium and cost-sharing subsidies, HHS/CMS should explore ways to complement and support state efforts in this area. Future administration guidance on exchanges is expected to offer more direction on quality improvement, but the opportunities for federal support are numerous.

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- 64 Miller, P., D. Love, E. Sullivan, J. Porter, A. Costello, "All-Payer Claims Databases: An Overview for Policymakers," *Academy Health, May 2010*, available at [http://www.statecoverage.org/files/SCI\\_All\\_Payer\\_Claims\\_ReportREV.pdf](http://www.statecoverage.org/files/SCI_All_Payer_Claims_ReportREV.pdf).
- 65 Designed to reduce uncertainty for health plans and keep premiums lower for participants, risk adjustment programs require health plans with healthier than average enrollees to pay into a fund, which is then tapped to compensate health plans with sicker than average enrollees. 76 Fed. Reg., 41930, 41931 (Jul. 15, 2011).
- 66 76 Fed. Reg., 41930, 41931 (Jul. 15, 2011).
- 67 *Ibid.* at 41941
- 68 ACA § 3011, adding new § 399HH to the PHSA.
- 69 HHS, Report to Congress: National Strategy for Quality Improvement in Health Care," Mar. 2011, available at <http://www.healthcare.gov/center/reports/quality03212011a.html>. To achieve the triple aims of better care, a healthier population, and more affordable care, the strategy articulates 6 priorities, including: (1) making care safer; (2) ensuring that each person and family are engaged as "partners" in their care; (3) promoting effective communication and coordination of care; (4) promoting the most effective prevention and treatment practices; (5) working with communities to promote best practices to promote healthy living; and (6) making quality care more affordable.
- 70 CMS, Medicare Managed Care Manual, Ch. 1, General Provisions, available at <http://www.cms.gov/manuals/downloads/mc86c01.pdf>.
- 71 *Id.*, at Ch. 11.
- 72 Medicare Payment Advisory Commission (MedPAC), "Report to Congress: Medicare Payment Policy," Mar. 2011, available at [http://www.medpac.gov/documents/mar11\\_entirereport.pdf](http://www.medpac.gov/documents/mar11_entirereport.pdf).
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- 76 Health Affairs Health Policy Brief, "Medicare Advantage Plans," Jun. 15, 2011, available at [http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief\\_id=48](http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=48).
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- 85 ACA § 1334.
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- 88 76 Fed. Reg. at 41892.
- 89 ACA § 1324.