



INTRODUCTION

In the current health care market, individuals and small employers are not getting good value for the health care dollars they spend. Too often, insurance premiums are unaffordable, and the quality of service and medical care is inconsistent. The new state insurance exchanges, currently being created under the Affordable Care Act, provide an important opportunity to improve access to high quality plans and providers for individuals and small business employees. However, to accomplish these goals, state insurance exchanges should not merely function as passive clearinghouses – simple websites where individual consumers and small business employees can choose among any licensed health plan. Instead, they should act as value purchasers and encourage participating health plans to use tools that are geared toward improving the quality and cost of services delivered to patients. Many large employers have adopted this approach to drive improved affordability and quality.

The Problem with the “Passive Clearinghouse” Model for the Exchanges

Some have argued for the passive clearinghouse model by saying that the exchanges must first ensure that their IT systems and business processes for eligibility determination, enrollment, and premium processing are working smoothly upon implementation in 2014. They say that exchanges do not have the luxury of putting in place standards for qualified health plans, performance measures for qualified health plans and their affiliated providers, or robust consumer choice tools. They also argue that consumers and small employers should be given the widest

possible choice of health plans. Setting up the infrastructure to manage a health insurance marketplace is a complex and difficult endeavor – simply “turning on the lights” will be a monumental task for the exchanges. However, using value-based purchaser strategies is also a critical and feasible start-up component given the availability of proven tools. If these strategies – especially performance measures – are not put in place at the beginning, it will be much more difficult to install them later. Furthermore, offering consumers a choice among all licensed health plans can overwhelm them with too many choices, and it would be administratively very costly for the exchanges. No large employer offers their employees a choice among all licensed health plans; employers are selective about which plans are available.

Why do large employers care about the quality of coverage the exchanges offer individuals and small business employees?

For years large public and private employers have tried to drive better value in the health care marketplace through a variety of strategies. Organizations like PBGH have provided an opportunity for these organizations to come together, align their strategies and share their best practices.

With the exchanges expected to cover an estimated 20 million new people, it is important for exchanges to send the health care marketplace the same signals as large private and public purchasers in order to achieve better cost and quality throughout the health care system.

An alternative approach is to learn from the lessons of large employers who have used value-based purchasing strategies. In addition to private employers, California and other states have successfully used these strategies to drive improved affordability and value in state coverage programs. Three key principles provide the foundation for a value-based purchasing strategy that exchanges and participating health plans can feasibly adopt.

PRINCIPLE 1

Set high standards for qualified health plans offered through the exchange

Explanation: State exchanges should act as value-based purchasers and set a high bar for participating health plans and their affiliated providers. Specifically, qualified health plans should be expected to.

- ▶ pay providers based on value (quality and cost) rather than traditional fee-for-service
- ▶ design benefits that provide incentives to consumers to use high-value providers, those who provide high quality care at the best price
- ▶ encourage innovation in the delivery of care, such as accountable care organizations, and primary care medical homes
- ▶ collect and publish data on the performance of providers
- ▶ encourage and support the meaningful use of health information technology

The exchanges should evaluate health plans based on these criteria and use the information to publicly recognize high-value health plans. The exchanges can also use this information for selective contracting and negotiation.

These standards should be established when the exchanges are launched; if health plans are unable to meet the standards initially, the exchange should

require compliance within a reasonable number of years. Initial standards can be based on existing model contracts and requests for information that have been widely used by large employers.

Large employer case study: Many large employers, including members of PBGH, use tools such as the Catalyst for Payment Reform's model contract language and the National Business Coalition on Health's eValue8 Request for Information (RFI) to query health plans about their practices and standards, before selecting which plans they will offer. Using these tools, employers gather information from health plans to evaluate their quality improvement efforts and other activities that control costs, minimize waste, and ensure patient safety.

Getting Started: Early Steps to Foster Value Based Purchasing

1. Collect and publish data on the performance of health plans and providers, beginning with information that is currently being gathered, e.g., HEDIS and CAHPS, which provide information on quality and patient experience. This will provide the foundation for qualified health plan evaluation and consumer choice tools.
2. Establish standards for participating qualified health plans based on existing model contracts and requests for information that have been widely used by large employers. This will establish expectations for qualified health plan performance and provide the basis for their evaluation in the initial year or in later years.
3. Provide consumer decision support tools that incorporate information on quality and cost.

PRINCIPLE 2

Improve the transparency of price and quality data

Explanation: In the current health care system, consumers and purchasers often lack useful data on the price or quality of the medical services they seek or receive. Exchanges can address this by collecting and disseminating information to help users compare among providers and treatment options on the aspects they care about. Specifically, exchanges should expect qualified health plans to provide performance data to their members and to the exchange on clinical outcomes, patient experience, care coordination, appropriateness of medical services and total cost.

Large employer case study: Safeway provides its employees with online tools (via its health plan and a third party vendor) that helps them view price data on many different types of treatment and services (such as laboratory tests) to help them choose the most affordable option before they go in for treatment.

PRINCIPLE 3

Offer tools to help consumers make the right health plan and provider choices

Explanation: Choosing the right health plan or provider is a challenging task for anyone. Exchanges have a critical role to play, helping consumers choose the right health plan and provider based on their medical needs and their financial situation. Foremost, exchanges should provide tools that allow consumers to make meaningful comparisons among health plans. The performance data from qualified health plans and their affiliated providers should integrate quality and cost information in a way that enables consumers to choose the plan that offers the best value to them. In addition, exchanges should integrate provider choice into the health plan choice process. For example, the right tools might help a pre-diabetic patient choose a

plan that offers first dollar coverage for primary care, and includes a network of providers proven to deliver the right diabetes care.

Combined with plan benefit designs that offer appropriate incentives, consumers will be encouraged to shop thoughtfully and pursue improvements in their health.

Large employer case study: Many large employers such as Wells Fargo offer tools to assist their employees to select the plan that best meets their needs. In the case of Wells Fargo, the online tool helps employees pick the best fit plan by asking them to estimate their medical needs and costs for the upcoming year. The Massachusetts Connector offers similar decision support tools to people enrolling in coverage through the state's Exchange.

The Right Tools For Health Plan Choice

Based on experience with these tools and other research, PBGH is developing a set of business rules that will help exchanges select the right consumer-decision support tools. Exchanges have already begun to incorporate these rules into requirements for their plan choice decision support software. More information is available at www.pbgh.org/exchanges

Conclusion

By following these principles and recommendations, exchanges will better serve their customers by offering high-value health plan and provider options. In addition, they will provide information and tools to help consumers choose the health plan and providers that best meet their needs. By aligning themselves with the actions of other public and private purchasers, exchanges can help to drive improved affordability and quality in the broader health care market.