

Health Insurance Exchanges, Quality and Value



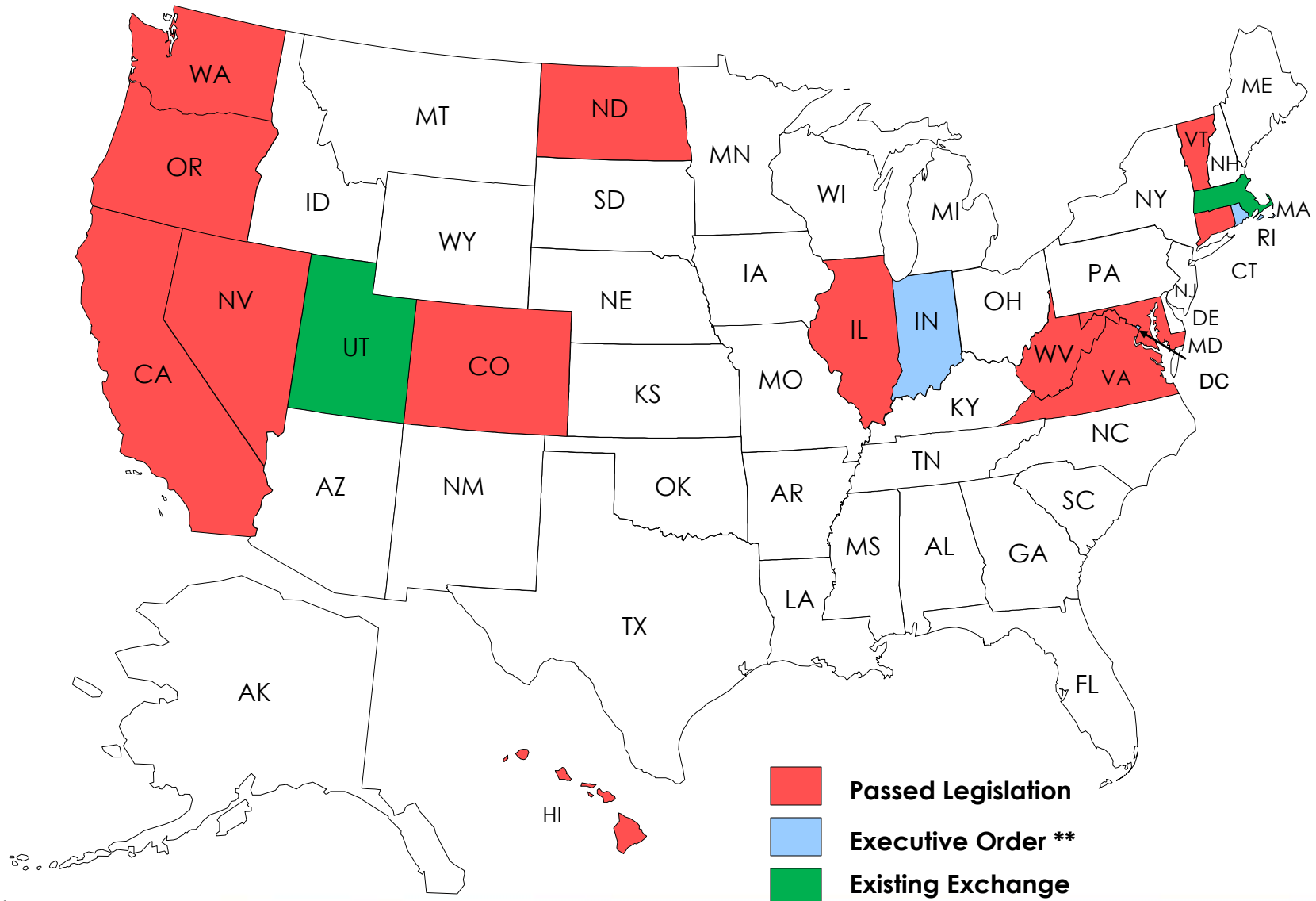
Agenda

- **Update on implementation**
- **A value agenda**
- **Quality measures, reporting and health plan rating**
- **Accreditation**

Timeline for Exchange Implementation

	2011	2012	2013	2014
Key dates			January 1 – States must demonstrate readiness	January 1 - Exchanges operational; subsidies available
Federal government	<ul style="list-style-type: none"> • Provide early innovator, establishment grants • Release guidance and regulations 	<ul style="list-style-type: none"> • Continue to release regulations 		
States	<ul style="list-style-type: none"> • Develop strategic plan • Pass legislation enabling Exchange • Develop operational plan • Select IT/Website infrastructure vendor 	<ul style="list-style-type: none"> • Implement operational plan • Select audit firm; vendors for outreach, marketing, navigators, call centers, financial systems 	<ul style="list-style-type: none"> • Complete IT/Website infrastructure • Select qualified health plans • Launch outreach campaign • Begin offering insurance 	

State Progress Report: Exchanges



- Passed Legislation
- Executive Order **
- Existing Exchange

Progress Report: Exchange Legislation

State	Structure	Governance
California 2010 SB 900 and AB 1602	Independent State Agency	5 Member Board
Colorado 2011 SB 200 , Chapter No. 246	Non-Profit	12 Member Board
Connecticut 2011 SB 921 , Public Act 11-53	Quasi-Public Agency	14 Member Board
Hawaii 2011 SB 1348 Act 205	Non-Profit	15 Member Interim Board
Illinois 2011 SB 1555 Public Act 197-0142	TBD	
Maryland 2011 SB182 (Chapter 1) & 2011 HB 166 (Chapter 2)	Independent State Agency	9 Member Board
Nevada 2011 SB 440 Chapter No. 439	Independent State Agency	10 Member Board
North Dakota 2011 HB 1126	TBD	
Oregon 2011 SB 99 , Chapter 415	Quasi-Governmental	9 Member Board
Vermont 2011 HB 202 , Act No. 48	Existing Agency	TBD by Deputy Commissioner
Virginia 2011 HB 2434 , Chapter No. 823	TBD	
Washington Chapter 317 , Laws of 2011 SB 5445	Public/Private Partnership	11 Member Board
West Virginia 2011 HB 408 , Act No. 100	New Entity within the Office of Insurance Commissioner	10 Member Board
Rhode Island EO 11-09	New Entity within the Executive Department	13 Member Board
Indiana EO 11-01	Non-Profit	TBD

Federal Regulations to Date

- **July 2011 – Two regulations**
 - One providing framework and flexibility
 - One on “the three R’s” – risk adjustment, risk corridors and reinsurance
- **August – regulations on HIT**
- **September – “Partnership model”**
- **To come**
 - Regulations relating to accreditation, quality reporting and overall quality improvement framework

Models and Functions of Exchanges

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

Exchanges: Opportunities to Drive A Value Agenda

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

QUALITY MEASURES

Who Are the Exchange Enrollees?

(Source: Kaiser Family Foundation)

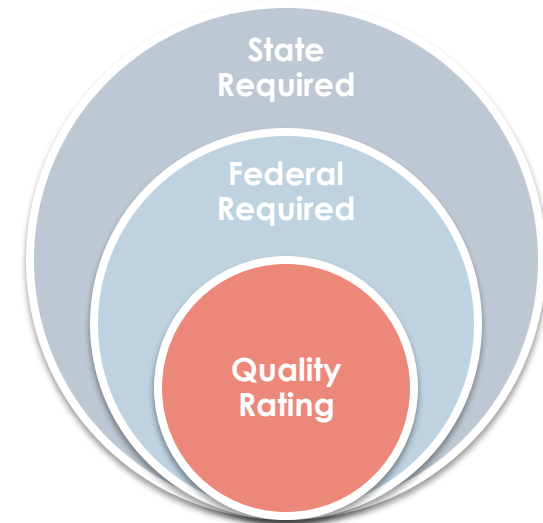
- The projected 2019 Exchange population is relatively older, less educated, lower income, and more racially diverse than current privately-insured populations
- Most enrollees transition from being previously uninsured; many currently experience access barriers
- They report worse health but have fewer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

Quality Measures: A National Starter Set

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

Quality Measures for Exchanges

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



- Exclude measures with low prevalence
- Composites
- Rolling average

Small numbers

- Combine Medicaid or Commercial with Exchange populations
- NCQA will align our data collection, reporting, Accreditation with requirements
 - Could include non-HEDIS measures

ACCREDITATION

Health Plan Qualification

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

Where We Are

Developing Concepts/
Revising Design



Draft Standards/Design
February 2012



Accreditation
Released July 2012

Phase-in of Accreditation Requirement

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

Transition pathways

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

Questions Around Accreditation

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

Concept Input Survey Results

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

Non-Discrimination in Marketing

Should NCQA add/modify our HPA standards to address:

Requirement:

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

Survey Feedback

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

Network Adequacy

Should NCQA add/modify our HPA standards to address:

Requirement:

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

Survey Feedback

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

Quality Improvement Strategy

Should NCQA add/modify our HPA standards to address:

Requirement:

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

Improves health outcomes

Reduces disparities

Wellness and health promotion

Reduces readmissions

Improves patient safety

Survey Feedback

These strategies should include:

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

Summary

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