



WHITE PAPER

Building State Exchanges to Get Better Value



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INTRODUCTION

State health insurance Exchanges will help many people obtain affordable health care coverage. Exchanges can do this by bringing individuals and small businesses together so they get better rates that only large groups can negotiate today.

Exchanges also have great potential to realign market forces if states build their Exchanges to promote competition among plans based on value, not just on premiums. Value means more than low premiums, which may reflect low quality or high cost-sharing barriers to care. Value is the quality of the health and well-being you get for the total cost you pay, which includes premiums, co-pays and deductibles.

Today, there is wide variation in cost and quality among insurers. High-value plans provide quality coverage efficiently. They coordinate care, avoid preventable problems, and work to keep people healthy. Low-value plans provide lower quality at higher cost in the long run when people need care for avoidable problems.

This variation in cost and quality persists because people rarely get information on plan value or help understanding how to compare plan value. The problem is compounded when people believe that more services automatically means better care (rather than waste and the potential for harm), or that more expensive care is always more effective. These mistaken beliefs severely limit the potential for market forces to promote value.

Exchanges can address this problem by helping consumers understand plan value and making it easy to find high-value plans. This encourages insurers to compete on cost and quality together, which can lower costs over time and foster a healthier, more competitive workforce. Exchanges that promote value may even help attract business to their state because of lower health costs and reduced absenteeism for employees in plans with stronger incentives to keep them healthy.

Georgetown University's Sabrina Corlette and JoAnn Volk identified "multiple opportunities" for Exchanges to promote reforms that improve value at plan and provider levels. Their paper, *The Role of Exchanges in Quality Improvement: An Analysis of the Options*, notes that some states are already building Exchanges to promote value.¹

¹ http://www.rwjf.org/coverage/product.jsp?id=72851&cid=XEM_910232



All states can take advantage of opportunities to promote value. This includes those that will accept all qualified plans in their Exchanges and “active purchasers” that want to negotiate and limit plan participation in Exchanges.

This paper describes several options for building Exchanges to promote better value:

- Helping Exchange Shoppers Understand Value
- Helping Exchange Shoppers Find High-Value Plans
- Helping Exchange Plans Provide Better Value

The following principles inform these recommendations:

- Present information to consumers as simply as possible. Studies and experience show that too much information can bog down the enrollment process (best case) or prevent someone from choosing a plan (worst case).
- Build from existing measures and data collection systems, to ensure straightforward and efficient implementation. This will help align efforts to improve quality and provide information on performance to consumers and regulators, limiting the burden on states, plans and the federal government.
- Limit data collection to data that have a clear use; there is considerable cost for reporting unused data.
- Add more information, new measures and quality improvement and assurance strategies over time. Give stakeholders the opportunity to comment on direction; give plans and states the opportunity to implement needed systems changes.

HELPING EXCHANGE SHOPPERS UNDERSTAND VALUE

One of the most important things Exchanges can do to promote value is help shoppers understand the need to look beyond just premiums, to:

- Total costs.
- Quality ratings.

Many Exchange shoppers will come from being uninsured, may have low health literacy and scant knowledge about total coverage costs or how to evaluate plan quality. Some may think low premiums mean better value. Others may think high premiums mean higher quality. Most will not know how to find or use information on total costs and quality. Exchanges that address this information gap will help people find plans that produce better outcomes at lower costs.

Key to Helping Exchange Shoppers Understand Value:

- *Help consumers understand the importance of total cost, including deductibles and copays, in addition to premiums.*
- *Help consumers understand the importance of quality ratings and how to use them when choosing a health plan.*
- *Make terms, cost and quality information is easy for consumers to understand.*

Total Costs: Exchange shoppers need to understand that they must pay deductibles and copays, in addition to premiums. Cost sharing may be significant in the lower-premium Bronze and Silver plans that will attract many modest income Exchange shoppers.

However, high cost sharing discourages people, especially those with modest incomes, from getting care.^{2 3} When that discourages use of necessary, cost-effective care, it leads to expensive, preventable problems. The need to treat preventable problems will continue to inflate health care costs and make coverage difficult to afford.

It is crucial that people understand all out-of-pocket costs they may incur, including premiums, copays and deductibles. Consumer Reports research shows that estimates of what the plan pays and what enrollees pay for common conditions, like having a baby or managing diabetes, works best.⁴ Such estimates help ensure that shoppers are not misled by low premiums alone and that they consider additional cost-sharing obligations when they choose a plan.

Quality Ratings: Exchange shoppers are not likely to know that Exchange plans must report on both clinical quality and “experience of care” measures.

Exchange plans must report their performance on measures of quality, like the HEDIS performance measures that NCQA collects.⁵ HEDIS measures evaluate

² *Healthcare Spending and Preventive Care in High-Deductible and Consumer-Directed Health Plans*, Buntin et al, American Journal of Managed Care, March 2011.

³ *Nearly Half of Families In High-Deductible Health Plans Whose Members Have Chronic Conditions Face Substantial Financial Burden*, Galbraith et al, Health Affairs, May 2011.

⁴ *Early Consumer Testing of the Coverage Facts Label: A New Way of Comparing Health Insurance*, Consumers Union, August 2011

⁵ HEDIS®, the Healthcare Effectiveness Data and Information Set, is a registered trademark of NCQA.



how well insurers provide proven, effective care that people need and prevent wasteful spending that does not help improve health. NCQA translates results into “report cards” with easy-to-compare data in terms consumers understand; for example, star ratings in categories like Staying Healthy, Getting Better and Living with Illness.

Exchange plans also must report on consumers’ experience of care, which the Consumer Assessment of Health Plans Survey (CAHPS) evaluates.⁶ CAHPS results provide easy-to-compare data on issues consumers understand and care about.

The survey asks whether enrollees get care when they need it, whether service representatives are courteous and helpful, and whether doctors listen and explains things well.

Exchanges that help consumers understand total cost and quality data will encourage insurers to compete on improving both their cost and quality scores. That is an essential first step in maximizing consumer-driven market forces to promote better value for individual and employer shopping for Exchange coverage.

HELPING EXCHANGE SHOPPERS FIND VALUE

Helping Exchange shoppers understand the importance of total cost and quality is an essential first step in helping them find the best value. The next step is making it easy for shoppers to find and use information on cost and quality when they choose a health plan. Exchanges can accomplish this through:

- Web portals and report cards.
- “Choice architecture.”

Most shoppers will not know how to assess complex cost and quality data, even if they understand the importance of total cost and quality. They also will not want to spend a lot of time evaluating plan choices. By structuring choices the right way, shoppers will not need to understand every detail. Exchanges that make cost and quality data easy to find and use will see more shoppers choose high-value plans with better outcomes at lower cost.

University of Oregon’s Judith Hibbard found that showing consumers clear and simple cost and quality information side-by-side helps them understand that they can get more for their money. Hibbard notes that consumers who understand quality are engaged in their own health care. Engaged consumers adopt healthier, preventive behaviors and seek more information about how to manage

⁶ CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality, which oversees the survey.

Key to Helping Exchange Shoppers Find Value:

- ***Ensure that Web portals, report cards, navigators, brokers and other resources make total cost and quality information easy to see, understand and use.***
- ***Present plan choices in formats that consumer testing shows help people choose high-value plans.***
- ***Require training for navigators and brokers on how to use quality and value ratings to help people choose high-value plans.***
- ***Build Exchange “choice architecture” in ways that encourage people to choose plans that provide the highest value.***
 - ***Rank plans by composite cost and quality scores, so consumers see top value plans first.***
 - ***Use visual cues like Star Ratings or letter grades, so consumers can easily identify plan value.***
 - ***Offer decision support tools, so consumers can prioritize the plan features most important to them.***

their conditions. They are more likely to take prescriptions as recommended, to know about treatment guidelines, to monitor their blood pressure. They also ask questions if they do not understand what their doctors are saying. As a result, they have fewer hospital readmissions, fewer medical errors and fewer problems from poor care coordination—and they use high-deductible health plans more effectively. All this can help keep people healthier while keeping costs down.⁷

Report cards, Web portals, and “choice architecture” that Exchanges use to present choices can help consumers understand value and, in turn, become more engaged in their own health care.

Report Cards and Web Portals: Exchanges will have Web portals and other tools to help shoppers evaluate plans. *How* Exchanges craft these plan-finding tools can have an enormous impact on whether shoppers choose high-value plans.

⁷ Alliance for Health Reform briefing on “Better Care—Lower Costs: Exploring the Promise of Patient Engagement,” March 5, 2010, http://www.allhealth.org/briefing_detail.asp?bi=179



Exchanges should “feature quality information as prominently as costs,” says Informed Patient Institute Executive Director Carol Cronin. Cronin analyzed 70 health plan report cards for AARP and found that the most useful ones “roll up” quality measures into a single score that consumer can interpret “at a glance.”⁸ They also let those who want more detail dig deeper.

To ensure that Web portals and report cards promote value, Exchanges should:

- Present easy-to-understand plan ratings that combine quality and cost rankings, for example, through star rating systems, based on composite scores from measures such as HEDIS and CAHPS that Exchange plans will report.
- Provide more detailed (but still easy-to-understand) plan ratings, for example on how well plans help enrollees “Stay Healthy,” “Get Better” and “Live with Illness.”
- Make it easy to see which plans are better at providing high-quality care that people want, like prevention and coordination, so they can avoid care they do not want, like preventable hospital stays and surgeries. (This information is included in HEDIS data.)
- Estimate total costs for common chronic conditions like diabetes and high-cost conditions like childbirth, so low premiums do not lure people into plans with high cost sharing.
- Require full accreditation for Exchange plans by no later than June 2014.
- Require accreditation that rates plan performance—not just “check-the-box” accreditation that assesses only minimum requirements—and build results into plan ratings.
- Educate navigators, brokers and other trusted sources that consumers use to help find the best value, and consider basing payment to navigators and brokers on how often they enroll people in high-value plans.
- Create tools to recommend high-value plans based on consumer preferences, such as doctors they want to keep or plans that manage a specific chronic condition well.
- Recommend high-value plans or automatically enroll people in such plans if they do not want to pick a plan. Such default enrollment is a powerful financial incentive for plans to improve their value ratings.

For more detailed information on ratings and decision support, see NCQA’s “Exchange Quality Solutions: Ratings and Decision Support Tools.”⁹

Choice Architecture: Marketers have long used choice architecture to influence shoppers, which is why candy bars and other impulse purchase items are in the

⁸ http://www.aarp.org/content/dam/aarp/health/medicare_insurance/2011-07/2011-cronin-report-final.pdf

⁹ <http://www.ncqa.org/LinkClick.aspx?fileticket=RNqdg-GjOnU%3D&tabid=61>



checkout lane. Even school cafeterias are beginning to use choice architecture to promote healthier choices. Making it easier to reach fruits and vegetables than French fries and deserts sells more fruits and vegetables, even though fries and desserts are still available. Exchanges that make high-value plans easier to reach will also have more shoppers choose high-value plans, even with other options still available.

Consumers Union's Lynn Quincy says Exchange planners should "abandon the image of a careful shopper capable of weighing the myriad costs and benefits of their health insurance options." Her research on how consumers make health plan choices shows they want value information, but need help finding it.¹⁰ Exchanges should provide shortcuts that make it easy to compare value and avoid jargon and complex math. Exchanges that do so will be more trusted by consumers and have more success promoting high-value choices.

Understanding how people make choices is critical when designing Web portals and report cards to promote value. The standard economics assumption that rational self-interest guides choice is often not the case, says Harvard School of Public Health professor Katherine Baicker.¹¹ People instead "have fallible judgment, malleable preferences, make mistakes, and can be myopic or impatient."

Choice architecture takes these realities into account to present information better, ensure that it is meaningful, and make high-value options easy to choose. It is especially important for Exchanges that let any qualified plan participate. Baicker says presenting too many options can lead to "choice paralysis" that causes people to either give up or make default choices based on biases or bad information. Choice architecture can prevent this by making it is easy to find and choose high-value plans, no matter how many options are available.

HELPING EXCHANGE PLANS PROVIDE BETTER VALUE

In addition to helping consumers find value, Exchanges can encourage insurers to promote value. Health plans have substantial ability to improve quality and value through:

- Patient engagement.
- Benefit design.
- Provider contracting and network design.

¹⁰ Early Consumer Testing of the Coverage Facts Label: A New Way of Comparing Health Insurance
<http://www.consumersunion.org/health.html>

¹¹ <http://www.hsph.harvard.edu/faculty/katherine-baicker/>

Key to Helping Exchange Plans Improve Value:

- ***Feature and reward plans that provide incentives to promote patient engagement through shared decision-making, wellness programs, and use of language patients understand and relate to.***
- ***Encourage “smart cost-sharing” in value-based insurance design to promote use of high-value, proven, cost-effective services and providers like Patient-Centered Medical Homes while discouraging low-value care.***
- ***Encourage plans to contract with high-value providers like Patient-Centered Medical Homes and accredited Accountable Care Organizations.***

Patient Engagement: Exchange plans can greatly improve value by working to engage patients themselves in improving their own health. There are several ways to do this.

Shared decision-making is an effective but still underused way to promote patient engagement. Shared decision-making tools include brochures, DVDs and Web sites that use plain language to explain treatment option pros and cons for conditions where there is no one clear choice. Shared decision-making engages patients because they become active partners instead of passive subjects to doctors' orders. Active partners are more likely to comply with treatment regimens, which improves outcome, and more apt to choose less costly options because they fully understand that risks and benefits of other options do not justify higher expense.

Wellness programs engage patients through personal health risk appraisal that identify health issues they can improve. The programs then help patients address those risks, for example through smoking cessation or weight loss programs and even cooking classes. Wellness programs also provide critical support to help people with chronic diseases comply with treatments and with dietary and other lifestyle changes, keeping them as healthy as possible.

Appropriate language is essential for patient engagement. Many Exchange enrollees will have limited English or health literacy skills. Using language they



understand and relate to is vital for explaining plan options, diagnoses and treatment instructions.

NCQA's Multicultural Health Care Distinction (MHC) program includes rigorous, practical requirements for insurers and other health care organizations to assess and improve efforts to meet members' cultural and linguistic needs.¹² Plans that achieve MHC distinction demonstrate that they communicate effectively with members.

Benefit Design: Exchange plans in the lower "Bronze" and "Silver" tiers will have substantial cost sharing, which can be a barrier to cost-effective care. Simply charging high cost sharing across the board for *all* services can actually lead to worse health and higher costs over time. High cost sharing reduces use of all health care services indiscriminately, including prevention and maintenance therapies for chronic conditions. People who skip these cost-effective treatments instead end up needing much costlier care for serious, preventable complications. This is especially true for people with low incomes, but also for those with moderate incomes.

Exchange plans that use "smart" cost sharing strategies can prevent underuse of high-value services and have healthier enrollees at lower costs in the long run. Smart cost sharing, also called "value-based insurance design" or "evidence-based benefit design," aligns incentives to promote high-value services that keep people healthy at lower cost.

Smart cost sharing programs lower or eliminate cost sharing for efficient and effective treatments proven to keep people healthy. This includes effective prevention and chronic care therapies for conditions like diabetes and high blood pressure, where research shows even modest cost sharing can keep people from getting care they need. Lower cost sharing greatly improves adherence to high-value care and prevents expensive complications.

Smart cost sharing originated with private sector companies like Pitney Bowes. It is becoming more common as its tangible benefits have become clearer, with strong examples in the Oregon Public Employee's health plan¹³ and champions at the University of Michigan.¹⁴ The Department of Health & Human Services features this in its National Quality Strategy¹⁵ and guidelines for implementing the new health reform law preventive services requirements.¹⁶ The National Business Coalition on Health also continually updates case studies and publishes a Health Value-Based Purchasing Guide.¹⁷

¹² <http://www.ncqa.org/LinkClick.aspx?fileticket=-sEvPOkSGfo%3d&tabid=61>

¹³ <http://pebb.das.state.or.us/DAS/PEBB/vision.shtml>

¹⁴ <http://www.sph.umich.edu/vbidcenter>

¹⁵ www.HealthCare.gov/center/reports

¹⁶ <http://www.gpo.gov/fdsys/pkg/FR-2010-07-19/html/2010-17242.htm>

¹⁷ <http://www.nbch.org/vbpguide>



Smart cost sharing programs also may increase costs for unproven, misused or low-benefit care, like the widespread inappropriate imaging for low back pain, to encourage people to consider alternatives. This part of the design can be challenging to implement but can be another effective way to lower spending. It works especially well with shared decision-making tools that explain treatment option pros and cons objectively in plain language.

Provider tiering is a related approach that lowers cost sharing for high-value providers. Some plans charge less when members get primary care from Patient-Centered Medical Homes. PCMHs provide well-coordinated, patient-centered care, expanded access and emphasize prevention and patient engagement. This improves outcomes and saves money by preventing the need for avoidable emergency department and hospital admissions. Plans also sometimes pay higher rates to PCMHs based on the PCMH recognition level they have achieved.

Similarly, some plans lower cost sharing for high-cost surgeries and procedures done at “Centers of Excellence” that have a proven track record of high quality, efficient care that gets good outcomes. Provider tiering also includes higher cost sharing to discourage members from using low quality or inefficient providers.

Smart cost sharing lowers total costs over time by preventing avoidable complications, surgeries, hospital stays and emergency department visits. Encouraging insurers to build smart cost sharing into Exchange plans will result in better patient health and better value for scarce health care dollars, and in Exchanges that are sustainable over time.

Provider Contracting and Network Design: Health plans can influence quality and value when they establish provider networks and contracts. They can include high-value providers like PCMH’s in their networks and exclude low-value providers. They can contract with NCQA-Accredited Accountable Care Organizations that have demonstrated the ability to coordinate high-quality, patient-centered care from medical homes to specialists, hospitals and beyond. They can adjust cost sharing to encourage use of high-value providers.

Plans can reward high-value providers with “pay-for-performance” based bonuses or default enrollment. They can require providers to report detailed performance data, analyze that data and share findings on where providers can improve quality and efficiency. All of these strategies have substantial potential to improve value.



CONCLUSION

State Health Insurance Exchanges have many options for using market forces to promote better value. Success, of course, depends on thoughtful implementation, tailoring to local preferences and building strong stakeholder consensus on the best approach in each state.

But failure is almost certain if states do not build Exchanges to promote on value. States that do not work to improve value will almost certainly have higher costs over time, less productive workforces due to preventable illness, and less affordable coverage in the long run.

NCQA has the experience, knowledge and staff necessary to help states achieve success. For 21 years, NCQA has pioneered and championed efforts to improve value through measurement, transparency and accountability, including report cards that provide quality information in terms consumers care about and understand.

- NCQA Health Plan Accreditation is the “Gold Standard” for assessing health plan quality. It provides rigorous, transparent scoring of access to care, clinical quality, patient experience, policies, procedures and consumer protections that Exchange plans must have.¹⁸
- NCQA has helped more than 3,500 primary care practices transform into Patient-Centered Medical Homes.¹⁹ PCMHs improve quality and both patient and provider satisfaction while reducing costly, preventable hospital and emergency department visits.^{20 21 22 23 24 25}
- NCQA is now driving broader health system transformation with our new Accountable Care Organization Accreditation program.²⁶

¹⁸ <http://www.ncqa.org/Portals/0/Public%20Policy/NCQA%20vs%20Other%20Accreditors.pdf>

¹⁹ http://www.ncqa.org/Portals/0/Public%20Policy/PCMH_2011_fact_sheet.pdf

²⁰ *Analysis of Community Care of North Carolina Cost Savings*, Milliman, January 2012

²¹ Cigna’s Collaborative Accountable Care Program with Medical Clinic of North Texas Shows Improved Quality, Lower Costs, <http://newsroom.cigna.com>, August 2011

²² *Reinventing Medicaid: State Innovations To Qualify And Pay For Patient-Centered Medical Homes Show Promising Results* Takach, Health Affairs, July 2011

²³ *Patient-Centered Medical Homes. A new way to deliver primary care may be more affordable and improve quality*, Cassidy, Health Affairs, September 2010

²⁴ *The Group Health Medical Home At Year Two: Cost Savings, Higher Patient Satisfaction and Less Burnout For Providers*, Soman et al, Health Affairs, May 2010

²⁵ *Driving Quality Gains And Cost Savings Through Adoption Of Medical Homes*, Field et al, Health Affairs, May 2010

²⁶ <http://www.ncqa.org/LinkClick.aspx?fileticket=oxGrmTX68Xg%3d&tabid=61>



- NCQA recently brought together experts and thought leaders from across the country for a conference on “*Exchanges: Driving a Value Agenda*,”²⁷ which helped to inform this paper.

NCQA is ready, willing and able to work with all states and stakeholders who want to pursue the approaches discussed in this paper.

²⁷ <http://www.ncqa.org/tabid/1212/Default.aspx>