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LEADING HEALTH CARE INNOVATION

Regulating Private Health Insurance to Promote High-Value Health Care

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Efforts by health care payers to encourage the provision of high-value health care date back at least to the 1990s. Initially, pay-for-performance and quality-reporting programs were sponsored by private insurers and employers. By the early 2000s, Medicare also launched demonstration projects using payment incentives and public reporting to encourage providers to improve the quality of health care. The Affordable Care Act of 2010, however, has added a new approach to the quest for high-value health care. It leverages federal regulation, funding, and reporting requirements to encourage private payers to incentivize providers to offer and consumers to seek out high-value health care.

Title I of the Affordable Care Act reforms our private health insurance system. Its best known provisions will, as of January 1, 2014, require insurers to make insurance available to all applicants without consideration of health status or preexisting conditions and provide federal tax credits to help lower-income Americans purchase insurance. Title I changes already in place have also outlawed problematic insurer practices such as lifetime dollar limits and coverage rescissions.

Title I is entitled, however, "Quality, Affordable Health Care for all Americans," and one of its primary concerns is improving the value of health care. The Title I private insurance value initiatives are, moreover, a part of a larger ACA value-improvement strategy, which comes most clearly into focus in Title III's mandate for a National Strategy to Improve Health Care Quality.

Title I creates a new section 2717 of the Public Health Services Act, which requires health insurers and group health plans to report to the Department of Health and Human Services (HHS), plan enrollees, and the public their "plan or coverage benefits and health care provider reimbursement structures" that improve health outcomes, prevent hospital readmissions, improve patient safety and reduce medical errors, and promote wellness and health.

Health insurers that wish to offer qualified health plans (QHPs) through the health insurance exchanges must, under section 1311 of the ACA, go further, affirmatively implementing provider-payment strategies that offer incentives to encourage providers to achieve these goals. In addition, qualified health plans are required to implement activities to reduce health and health care disparities.

The ACA requires QHPs to be accredited and meet accreditation requirements for quality assurance and quality reporting and requires exchanges to rate QHPs on the basis of quality and price. QHPs must report to their enrollees, prospective enrollees, and the exchange their performance on health plan quality measures. Finally, the ACA provides that, as of January 1, 2015, QHPs may contract only with hospitals with more than 50 beds that utilize a patient-safety evaluation system that meets specified standards and that implement a comprehensive hospital discharge program. As of that date, plans may also contract only with health care providers that implement

quality-improvement mechanisms required by HHS regulations.

Private insurers are not new to value-based benefit designs and provider-incentive programs. (http://www.commonwealthfund.org/Publications/Fund-Reports/2012/Apr/Health-Plan-Quality-Improvement-Strategy.aspx?page=all) Many health plans currently offer incentives such as reduced cost sharing to members who choose evidence-based treatments or high-value providers, who use preventive screenings, who take maintenance medications regularly, or who participate in self-care and care-management programs. Plans also provide consumers with decision-support tools and health coaching. Episode-based or capitated payment systems incentivize providers to coordinate care and keep their patients healthy. Payment systems that take into account patient outcomes further reward high-value care.

Despite the fact that private health plans are already engaged in programs to encourage high-value health care, HHS has put off full implementation of the ACA's health-plan quality requirements. HHS has failed to implement section 2717, even though the law mandated that HHS develop reporting requirements by 2012. It has not yet implemented ACA section 10329, which requires HHS to develop a methodology to assess health plan value, considering quality, cost, efficiency, risk to enrollees, and other factors. HHS announced in 2011 that it would delay rulemaking on QHP-specific exchange quality-reporting requirements until 2016 for the 2017 open-enrollment period. Until then, the exchanges will use available quality data, such as the Healthcare Effectiveness Data and Implementation Set (HEDIS). (http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/ffe-guidance-05-16-2012.pdf) HHS has recently released a notice describing its proposed Quality Rating System. (http://www.ofr.gov/OFRUpload/OFRData/2013-27649_PI.pdf)

Of course, it is not possible for HHS to demand quality data on QHPs for 2014, because they do not yet exist and thus have no track record. Moreover, given the very limited resources the federal government has available to implement the ACA, it is not surprising that HHS has chosen to put other priorities, such as establishing the exchanges and the federal data hub, ahead of quality reporting.

Despite the lack of leadership from HHS, however, a number of state exchanges are moving ahead with quality reporting. A recent study found that as of May 31, 2013, nine state exchanges planned to display plan quality metrics on their Web sites and ten planned to rate QHPs on the basis of quality for 2014. (http://www.commonwealthfund.org/Publications/Fund-Reports/2013/Jul/Design-Decisions-for-Exchanges.aspx) Most state exchanges will require plans to submit written narratives describing their quality-improvement strategy or to meet state quality-improvement requirements.

HHS has, moreover, implemented one ACA provision relevant to health-plan quality improvement. Section 2718 of the Public Health Services Act, added by the ACA, requires insurers in the nongroup and small-group markets to spend at least 80% (and large-group insurers 85%) of their premium revenues on medical claims and on "activities that improve health care quality." Insurers who fail to do so must pay a rebate to their enrollees.

The statute does not define quality-improvement activities, but an implementing regulation promulgated by HHS following the recommendation of the National Association of Insurance Commissioners does. Among other requirements, this regulation mandates that quality-improvement activities "increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements" and "be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations." (45 C.F.R. § 158.150). Quality-improvement activities must also be designed to improve health outcomes, prevent hospital readmissions, improve patient safety and reduce medical errors, increase wellness and health activities, and enhance the use of health data to improve quality and support meaningful use of health information technology (HIT).

During 2011, the first year this requirement was in effect, insurers reported spending $2.3 billion — 0.74% of premium reve-

nues—on quality-improvement activities, an average of $23 per member. (http://www.ncbi.nlm.nih.gov/pubmed/23547337) Insurers who broke down their expenses further reported that 51% of expenses were devoted to improving outcomes and 17% to HIT. The amount spent varied dramatically by insurer, and also by type of insurer—with provider-sponsored insurers spending the most and for-profit insurers the least. The effectiveness of these expenditures remains to be established.

In adopting the ACA, Congress embraced an ambitious agenda of regulation and public reporting to encourage private insurers to improve the value of health care. Congress tried to encourage insurers to pursue activities that some were already pursuing and to emulate value-purchasing initiatives in the Medicare and Medicaid program. HHS seems, however, to have made private insurance value purchasing a low priority. It is likely to be several years before we learn whether the ACA provisions that address private insurers will in fact improve the value of health care.