October 4, 2010

Secretary Kathleen Sebelius
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
330 C Street
Washington, D.C.

Dear Secretary Sebelius:

On behalf of the National Business Coalition on Health, we wish to thank you for inviting public comment regarding the exchange-related provisions in Title 1 of the Patient Protection and Affordable Care Act. In this letter we will address a subset of the questions you have raised in the request for comments published in the Federal Register issue of Tuesday, August 3, 2010. A list of our health coalition members is in Attachment 2.

As an employer-centric group, we are particularly interested in the leverage that the Act and Exchanges can have on consumer health status and cost. Over the past ten years so we have worked with the CDC, AHRQ, HHS and other organizations and experts to convert the evidence that identifies the drivers of health status and cost into standards and expectations that employers should deploy in their selection and interaction with health plans, doctors and hospitals. With that in mind, the thrust of our comments can be consolidated into a few principles related to exchanges

- Require plans to report on their status with respect to certain important indicators
- Require participating plans to pool their data (preferably joining with region-wide carriers) to enable performance reporting at the physician level
- Require exchanges to convene a dialogue between plans and their employer/consumer customers setting specific goals and targets for improvement
- Require plans to leverage their information to support doctors and consumers (e.g. to close gaps in care)
- Require plans to advance the role of primary care and to facilitate the transition to a broader role and greater accountability at the primary care practice level
- Require exchanges and plans to transform the provider payment system from fee for service to population-based and outcomes-based payments
- Require exchanges to provide consumers with information about their health plan choices that includes both calculators for out-of-pocket exposure and tools/services available that will help them stay healthy
- Require exchanges to deploy and aggressively promote consumer education in areas that include the variability in provider quality, the importance of (meaningfully used) electronic records, how to select a doctor.

Detailed comments and our membership list are attached.

Sincerely,

Andrew Webber

Andrew Webber, President & CEO

Attachment 1
Question-specific Comments

The following are recommendations and comments responding to specific questions posed in the Federal Register. All of the health plan-related suggestions have a basis in the evidence-based metrics of NBCH's health plan performance evaluation tool called ***eValue8***.

C. State Exchange Operations Section 1311(b) and (d)

2. For which aspects of Exchange operations or Exchange standards would uniformity be preferable?

COMMENT: In order to avoid confusion among consumers moving from state to state and consulting family and friends about health issues and choices, it is our opinion that there should be centrally developed tools for

- Cost calculators (similar to Medicare Part D where consumers can explore the out-of-pocket impact of various assumptions of the need for specific drugs and services)
- Benefit comparisons uniformly defining coverage and out-of-pocket liability
- QHP performance indicators (e.g. HEDIS)
- QHP availability of consumer tools (e.g. personal health records, shared-decision technology)
- Educational content regarding the variability in quality among providers, importance of electronic records, safety precautions when hospitalized, etc.
- Provider performance indicators (e.g. procedure volumes, percent with complications, mortality rates, readmission rates, patient adherence rates and, eventually, rates of in-control biometric measures)

5. What are the considerations for States as they develop web portals for the Exchanges?

COMMENT: See #2 above. It will be important not to overlook the web requirements for the listed items for consumer access, some of which involve integration and organization of QHP-specific and provider-specific information.

6. What factors should Exchanges consider in reviewing justifications for premium increases from insurers seeking certification as QHPs?

COMMENT: QHPs should be held accountable for exerting some control over efficiency and quality. They should be required to carry out strategies that address the unwarranted variability in utilization and prices nationally and regionally. Rate reviews should consider their effectiveness in executing those strategies that might involve greater emphasis on primary care, tiering of providers and provider payment reform. QHPs should also be required to extend actuarial analysis beyond the limits of claims history and demographics by integrating other factors that will have an impact on trend itself. This includes plan design factors such as consumer incentives to adopt healthy behaviors (smoking cessation, adherence to clinical guidelines and physician orders, etc.). To provide a very specific example, the dollar value of a one point change in HbA1c value should be integrated into both payment reward strategies and the actuarial lexicon.

E. Quality

1. What factors are most important for consideration in establishing standards for a plan rating system?

a. How best can Exchanges help consumers understand the quality and cost implications of their plan choices?

COMMENT: Education is paramount. Consumers have been blind to every aspect of health care ranging from cost to quality to behavioral influences. The Act provides an opportunity to deliver objective and wide-spread messages to consumers. The range of quality measures needs to be expanded beyond that which is commonly available (see b. below) and the vehicles for education need to be expanded to meet consumers where they are and when they are ready to hear it. The Exchanges should

- Provide provocative questions that spur consumers to learn more about specific topics and to dispel myths in health care (e.g. higher cost means higher quality), the importance of electronic records, the variability of quality among providers,
- Provide information about a variety of plan quality topics leading up to a decision about which plan to choose in a manner that is well organized and in which a consumer can select and rank the importance of specific quality issues (e.g. ratings by other consumers, availability of consumer tools and support, aggregate information about how well plan members are controlling chronic conditions, etc.)
- Provide cost calculators that are specific to plan design alternatives, provider network chosen and specific circumstantial scenarios regarding the presence of chronic conditions and the projected use of specific services and pharmaceuticals (cf. Medicare Part D)
- Meet consumers where they are through a variety of interactive media including mail, email, the Web, social media vehicles.

b. Are the measures and standards that are being used to establish ratings for health plans in the Medicare Advantage program appropriate for rating QHPs in the Exchanges? Are there other State Medicaid or commercial models that could be considered?

COMMENT: Medicare measures are centered on the elderly. Many of the HEDIS and CAHPS measures applied to both the Medicare and commercial populations are appropriate, but more are needed. There is a commercial model used by hundreds of public and private employers in as many as 40 states historically. The ***eValue8*** program of the National Business Coalition on health is an evidence-based request for information formed and revised over the past ten years by and for purchasers with the assistance of the CDC, AHRQ, SAMHSA, HHS and other organizations and clinical experts. ***eValue8*** is populated by measures that are primarily concerned with the drivers of health status and efficiency. It aligns with and captures many of the relevant NQF-approved measures, but also extends beyond them. In addition to

HEDIS and CAHPS, some of the additional measures included in ***eValue8*** are as follows:

- Consumer engagement
    - Ability to administer a variety of value-based benefit designs that provide for consumer incentives to adopt healthy behaviors and make cost-effective choices.
    - Comprehensiveness of programs and interventions that identify and assist consumers according to their circumstances and preferences.
        - Prevention and health promotion
        - Disease management
        - Behavioral health
        - Special attention to aggressively closing gaps in care (adherence to guidelines for preventive services and chronic care)
        - Connections to primary care (these interventions and services are most effective when coming from or coordinated with the physician's office)
    - Comprehensiveness of consumer tools that leverage plan information and resources to assist consumers in making choices that are right for their circumstances.
        - Doctor and hospital selection tools populated with quality information and office/facility capabilities (EHR, eRx, email, web visits, PCMH certifications, etc.)
        - Prepopulated personal health records with outbound messaging tailored to the consumer's circumstances
        - Shared decision technology
        - Cost calculators
    - Education, promotion and evaluation of the plan's consumer tools
    - Racial, cultural and language competency
- Provider measurement, rewards and support
    - Participation in regional collaboratives to align initiatives and to pool data enabling, for example, performance reporting at the physician level (this should be a requirement of QHPs)
    - Measures of waste (preventable admissions, readmissions, potentially avoidable costs, overused procedures)
    - Measures of errors and safety (Leapfrog, AHRQ, treatment of serious reportable conditions and healthcare acquired conditions)
    - The specific measures used by the plan, and their reach for purposes of feedback and rewards
    - Types and significance of rewards/payment reform efforts
    - Coordination with and practice integration of the plan's consumer services and support tools (care management, smoking cessation, closing gaps in care, etc.)
    - Measures of support for and the penetration of HIT in the provider network

c. How much flexibility is desirable with respect to establishing States-specific thresholds or quality requirements above the minimum Federal thresholds or quality requirements?

COMMENT: There should be a very robust set of measures that are required at the federal level, with ample opportunity for states to add to the list and capitalize on local circumstances and opportunities. Markets will have very different characteristics that will enable or impede elements like provider reporting and accountability that the plan should play a role in through its contractual relationships. The federal threshold should not be static, but evolve toward the best practices among the states.

2. What are some minimum standards or other factors that could be considered with respect to establishing quality measurement and improvement thresholds or quality requirements that should be met by QHPs? What other strategies, including payment structures, could be used by plans to improve the practices of plan providers?

COMMENT: The Disclosure Project guidelines should be followed in establishing reporting priorities, placing NQF approved measures at the top. Exchanges should be required to share minimum measure results federally and HHS or a designated agency should provide national distributions of results integrate them with results from the commercial market where possible. Reporting priorities should be governed by the evidence identifying each measure as an outcome or a significant driver of health status or cost. Unfortunately, many of the measures currently used are process measures and not good indicators of health status. (e.g. persons with diabetes taking HbA1c tests according to guidelines is not well correlated to HbA1c control.) Initially, the HEDIS/CAHPS set of measures are well specified and widely used. We recommend a rapid movement toward approved measures for specific elements identified in 1b above. These include measures of

- Waste
- Clinical outcomes (e.g. BMI/circumference, blood pressure, more lab values)
- Gaps in care (e.g. Rx possession ratios for critical persistent medications)
- Extent and significance of payment reform transformation in the QHP's network (moving away from fee for service and toward population- and outcome-based payments)
- Network evolution toward primary care focus and accountability
- Presence and completeness of consumer tools and support for specific needs

Exchanges should be charged with the responsibility of convening quality action coalitions of stakeholders, dominated by purchasers and consumers. Those coalitions will review all of the reported quality measures, establish priorities and work with QHPs to agree on strategies and targets for improvement.

Payment reform is still evolving, so we would encourage continued study for models that include episodic reimbursement, shared savings, and population-based payments. We think that it is important to combine provider incentives with consumer incentives, so the plan design parameters that HHS and Exchanges develop should allow for this.

J. Consumer Experience

1. What information are consumers likely to find useful from Exchanges in making plan selections?

COMMENT: In addition to comparisons of coverage, copays, participating providers, it is important to provide information about other services, support and tools provided as listed in E.1.a. above (availability of support for chronic conditions, self-management tools, rewards for program participation, etc.). There should be calculators available that allow eligibles to estimate their out-of-pocket exposure. The calculator should not only incorporate the plan design elements (copays, deductibles), but allow the consumer to specify clinical conditions and use of specific services in the coming year (perhaps based on the past year). The Medicare Part D calculators provide an example of this.

It is suggested that there be lower cost plan options that are tied to behavioral "rules" and that consumers be educated about that option. This value-based design option would require completion of a personal health assessment and adherence to preventive services and chronic care guidelines. Some commercial plans have engaged actuaries to estimate a premium differential associated with such a plan and it is recommended that HHS investigate this as a possible addition to the actuarial lexicon.

Attachment 2
NBCH Members

Alabama
ECHO - Employers Coalition for Healthcare Options

Arkansas
Employers' Health Coalition

California
Pacific Business Group on Health

Colorado
Colorado Business Group on Health

Florida
Florida Health Care Coalition

Georgia
Savannah Business Group on Health

Hawaii
Hawaii Business Health Council

Illinois
Employers' Coalition On Health
Heartland Healthcare Coalition
Midwest Business Group on Health
Tri-State Health Care Coalition

Indiana
Indiana Employers Quality Health Alliance
Tri-State Business Group on Health

Kansas
Wichita Business Coalition on Health Care

Louisiana
Louisiana Health Care Alliance

Maine
Maine Health Management Coalition

Maryland
MidAtlantic Business Group on Health

Michigan
Michigan Purchasers Health Alliance

Minnesota
Buyers Health Care Action Group
Labor/Management Health Care Coalition of the Upper Midwest

Missouri
Mid-America Coalition on Health Care
St. Louis Area Business Health Coalition

Montana
Montana Association of Health Care Purchasers

Nevada
Health Services Coalition
Nevada Health Care Coalition

New Jersey
New Jersey Health Care Quality Institute

New York
New York Business Group on Health
Niagara Health Quality Coalition

North Carolina
Piedmont Health Coalition, Inc.
Western North Carolina Health Coalition

Ohio
Employers Health Purchasing Corporation of Ohio
FrontPath Health Coalition
Health Action Council Ohio

Oregon
Oregon Coalition of Health Care Purchasers

Pennsylvania
Employers Health Coalition of Pennsylvania, Inc.
Lancaster County Business Group on Health
Lehigh Valley Business Coalition on Health Care
Pittsburgh Business Group on Health

Rhode Island
Rhode Island Business Group on Health

South Carolina
South Carolina Business Coalition on Health

Tennessee
Healthcare 21 Business Coalition
Memphis Business Group on Health

Texas
Dallas/Fort Worth Business Group on Health
Houston Business Group on Health
Texas Business Group on Health

Virginia
Virginia Business Coalition on Health

Washington
Puget Sound Health Alliance

Wisconsin
The Alliance
Business Health Care Group
Fond Du Lac Area Businesses on Health
Greater Milwaukee Business Foundation on Health, Inc.
WisconsinRx and National CooperativeRx

Wyoming
Wyoming Business Coalition on Health