National Business Group on Health

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Creative Health Benefits Solutions for Today, Strong Policy for Tomorrow

November 21, 2011

Mr. Steve Larsen
Director
Center for Consumer Information and Insurance Oversight (CCIIO)
Centers for Medicare & Medicaid Service (CMS)
U.S. Department of Health and Human Services (HHS)
Attention: CMS–9989–P, RIN 0938–AQ67
P.O. Box 8010
Baltimore, MD 21244–8010

Dear Director Larsen:

The National Business Group on Health writes to urge you to ensure the capability of the exchanges and exchange boards to meet the growing consumer demand for provider and facility-specific price and quality information. The cost of health care services varies widely within networks and regional markets. As more Americans pay out-of-pocket for a greater percentage of their health care, they deserve better information about the relative prices of treatment options and providers. A recent Government Accountability Office (GAO) report concluded that consumers have difficulty obtaining meaningful price information before receiving care.[1]

Specifically, we recommend CCIIO require that exchange plans provide consumers with meaningful, timely and user-friendly information via online benefits portals and by phone that allows them to shop for health care based on quality, value and their personal preferences and needs. Health plans and technology vendors continue to develop transparency platforms and strategies to successfully engage consumers in making informed decisions. As a by-product, transparency of information will help create a truly competitive health care marketplace and improving consumers' choice of high quality, efficient providers, both inside and outside of the exchanges, represents the best chance to achieve significant savings in national health care spending.

We recommend the exchanges allow all plans that meet certification requirements to participate rather than limiting access to plans selected by the exchanges. However, CCIIO must set high transparency and quality standards to ensure the exchanges do not become passive facilitators or only "portals" for individuals and employers to select health care coverage. We also continue to applaud CCIIO for the provisions in the proposed rule that would promote administrative simplicity and national uniformity and

[1] Health Care Price Transparency: Meaningful Price Information is Difficult for Consumers to Obtain Prior to Receiving Care. US Government Accountability Office Report to Congressional Requesters. September 2011. Available at: http://www.gao.gov/products/GAO-11-791

the potential of the exchanges to promote competitive marketplaces and transform the nation's health care delivery system.

The National Business Group on Health represents over 330 companies, including many of America's largest employers (67 of the Fortune 100) who voluntarily provide health benefits and other health programs to over 55 million American employees, retirees, and their families.

Many of our members and other employers may interact with the exchanges if they have potentially eligible populations (individuals with coverage the government deems "unaffordable" or not "comprehensive", low-to-moderate income employees (up to 400% of federal poverty or $74,120 for a family of three), early retirees, COBRA eligibles, spouses, dependents or contract, part-time, seasonal or temporary employees) in 2014 and if states or the District of Columbia permit them to participate in 2017. In addition, the exchanges represent a unique opportunity to transform the way we pay for and deliver health care. Therefore, our members want to make certain that exchanges promote high quality, affordable, clinically appropriate and evidence-based care to the individual. CMS has made a number of advances in these areas and the hospital value-based purchasing (VBP) program and the Medicare shared savings program that creates Accountable Care Organizations (ACOs) provide useful references for meeting quality benchmarks, but both of these programs still have room for improvement.

In our exchange model and our September 26th comment letter on the proposed rule, we recommended that CCIIO:

- Require the exchanges to be highly active purchasers and assure that plans that meet the high standards are able to compete for patients in the exchange;
- Continually set high quality standards for plans to participate in the exchanges;
- Require all exchanges use the National Committee for Quality Assurance's (NCQA) highest rating for accreditation—"Excellent"—as the standard for qualified health plans (QHPs) participating in the exchanges,
- Require every exchange to appoint a Chief Value Officer to maintain organizational focus on the value of the exchanges and health care services; and
- Require exchanges to maintain a rigorous focus, well beyond premiums and administrative costs, on reducing the total costs of care in the health care system.

We also make the following recommendations to the initial proposed rule, which reflect the specific transparency recommendations of our member companies:

Require Transparency of Provider-Specific Price and Quality Information

HHS should ensure the exchange policies and the health plans are clear to consumers, employers, the States and the federal government. That calls for clarity and simplicity. HHS should not micromanage participating health plans; but rather, provide a clear focus on innovative purchasing and a value agenda for health care in the community.

Benefits portals under development in the private sector have the following characteristics that exchanges should emulate:

Content

- Provider-specific pricing for specific health care services in primary care, pediatrics, specialty care, lab tests, imaging, physical therapy and pharmacy. When permitted, plans should report contracted rates. Purchasers can also calculate prices from historical claims data when plans prohibit the disclosure of contracted rates.
- Provider-specific quality information, including easily accessible provider ratings and evidence-based treatment guidelines.

Features and Functionality

The health plans' and technology vendors' transparency platforms can do the following:

- Accommodate a variety of plan designs including consumer directed health care and reference-based pricing;
- Integrate data from all carriers and vendors serving consumers;
- Integrate with related portal tools, e.g. nurse click to chat, decision support tools, etc.;
- Integrate with mobile applications;
- Display side-by-side comparisons of provider-specific price and quality information;
- Provide automated, personalized alerts, e.g., when patients should receive recommended preventive care screenings;
- Provide real-time user supports both online and telephonic during specified hours; and
- Utilize privacy and security best practices, including compliance with existing federal laws (HIPAA, HITECH, etc.).

Consumer Portal

Benefits portal features include:

- A single sign-on and link from a home page;
- Personalized portals, e.g., password protected, consumers can see where they stand on deductibles and health fund usage, view coverage details, etc;
- Ability for enrollees to manage everything from one place, e.g., see all dependents and claims history in their plans, etc.;
- Search options on providers and to view costs, quality and personal benefit data;
- Real-time navigator assistance tools to help enrollees choose plans and ask questions regarding benefits, cost-sharing, quality, cost and performance;
- Email contact with providers;
- Care decision-support tools, e.g., procedure/treatment indications, options, benefits and risks;

- Tools to schedule appointments and complete paperwork; and
- Tools to review consumer ratings and rate providers.

Performance Expectations

Exchanges should emulate employers' efforts to provide plan enrollees with their plans' performance expectations and require that plans:

- List their expectations to achieve the continually improving set of high quality standards set by the exchanges and the exchange boards.
- List their utilization rates (higher use services, etc.) to allow the plans, the exchanges and the exchange boards to target procedures identified by the Institute of Medicine (IOM) as unnecessary services, inefficiently delivered services, excess administrative costs, high prices, missed prevention opportunities and fraud; and
- List accurate prices as referenced above under content.

Future Plan Changes

Exchanges should also emulate employers' efforts to determine when plans will update their functionality and transparency requirements.

We look forward to continuing to work with the CCIIO on this process. Please contact me or Steven Wojcik, the National Business Group on Health's Vice President of Public Policy, at (202) 558-3012, if you would like to discuss our comments in more detail.

Sincerely,

Helen Darling
President and CEO

cc: The Honorable Donald Berwick, M.D., Administrator, CMS
The Honorable Kathleen Sebelius, Secretary, HHS