The COMMONWEALTH FUND

REALIZING HEALTH REFORM'S POTENTIAL

JULY 2014

Implementing the Affordable Care Act: State Action on Quality Improvement in State-Based Marketplaces

Sarah J. Dash, Sabrina Corlette, and Amy Thomas

Abstract Under the Affordable Care Act, the health insurance marketplaces can encourage improvements in health care quality by: allowing consumers to compare plans based on quality and value, setting common quality improvement requirements for qualified health plans, and collecting quality and cost data to inform improvements. This issue brief reviews actions taken by state-based marketplaces to improve health care quality in three areas: 1) using selective contracting to drive quality and delivery system reforms; 2) informing consumers about plan quality; and 3) collecting data to inform quality improvement. Thirteen state-based marketplaces took action to promote quality improvement and delivery system reforms through their marketplaces in 2014. Although technical and operational challenges remain, marketplaces have the potential to drive systemwide changes in health care delivery.

For more information about this brief, please contact:

Sabrina Corlette, J.D.
Senior Research Fellow and Project Director
Center on Health Insurance Reforms
Georgetown University Health Policy Institute
sc732@georgetown.edu

Commonwealth Fund pub. 1763
Vol. 18

OVERVIEW

Health care quality in the United States is widely recognized to be highly variable, with many Americans not receiving needed care and others receiving uncoordinated, unnecessary, or even harmful services.[1] While public and private health care purchasers have taken promising steps to achieve the three-part aim of improved health, better quality, and lower health care costs, their success to date has been inconsistent.[2] The new health insurance marketplaces created by the Affordable Care Act have the potential to improve the quality and cost-effectiveness of health care in the individual and small-group markets by establishing a common set of quality improvement requirements for participating insurers and creating a competitive shopping experience in which consumers can more easily compare plans on quality and value.[3]

The Affordable Care Act includes a number of standards intended to encourage private health insurers to improve quality of care and develop innovative delivery system reforms (Exhibit 1).[4] These include requirements

that insurers selling plans in the marketplaces be accredited, report on quality and performance metrics, and implement quality improvement strategies.[5] However, there are challenges to implementing these and other quality requirements: difficulty comparing pre-marketplace health plans with marketplace plans because of potentially different provider networks, benefit structures, and patient populations; the emergence of new commercial insurers for which no quality data exist; the lag time involved in quality data reporting; and the need for adequate enrollment in marketplace plans to ensure the statistical validity of quality measurement and reporting.[6] The U.S. Department of Health and Human Services is phasing in the quality requirements, but states may implement them earlier or tailor them to achieve state-specific goals.[7]

Exhibit 1. Affordable Care Act Quality Requirements for Qualified Health Plans

Requirement	Description	Effective Date
Accreditation	• Marketplace insurers must be accredited on the basis of local performance of their qualified health plans (QHPs) in categories including clinical quality measures (as measured by HEDIS) and patient experience ratings (as measured by CAHPS).[a]	Fully accredited by fourth year of certification as a qualified health plan
Quality improvement strategy	• Qualified health plans must implement a quality improvement strategy to prevent hospital readmissions, improve health outcomes, reduce health disparities, and achieve other quality improvement goals.	2013 for the 2014 plan year
Quality reporting	• Qualified health plans must report to the marketplace, enrollees, and prospective enrollees on health plan performance quality measures. • All nongrandfathered plans inside and outside the marketplace must submit an annual report to HHS and to enrollees regarding whether benefits under the coverage or plan satisfy quality elements similar to those in the quality improvement strategy.[b]	2016 for the 2017 plan year
Quality rating system	• Secretary of HHS must develop a rating system and enrollee satisfaction survey system for qualified health plans. • Marketplace websites must display federally developed quality ratings and enrollee satisfaction information to consumers. • State marketplaces may display their own quality rating systems prior to 2016; beginning in 2016, they may display a state-specific quality rating system in addition to the required uniform federal quality rating system.	2016 for the 2017 plan year
Additional quality requirements	• Medical loss ratio: health insurers must spend at least 80 percent to 85 percent of revenue on health care and quality improvement.[c] • Patient safety: qualified health plans must comply with patient safety regulations.[d]	2012 (medical loss ratio) 2015 (patient safety)

[a] Healthcare Effectiveness Data and Information Set (HEDIS) is a registered trademark of the National Committee for Quality Assurance (NCQA) and is included in NCQA accreditation. HEDIS shows how often health insurance plans provide scientifically recommended tests and treatments for more than 70 aspects of health. Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a registered trademark of the Agency for Healthcare Research and Quality and is included in NCQA and URAC (formerly known as the Utilization Review Accreditation Commission) accreditation. CAHPS surveys patients' own experiences of care, including timely access to care and overall views of health plans and doctors.

[b] Nongrandfathered plans are health plans created after March 23, 2010, or those that were in existence on or before March 23, 2010 but did not meet regulatory criteria for remaining grandfathered.

[c] Under the Affordable Care Act, health plans in the individual and small-group markets must spend at least 80 percent of revenues on health care and quality improvement; for large-group plans, the minimum medical loss ratio is 85 percent.

[d] Beginning in 2015, QHPs may only contract with hospitals with greater than 50 beds if they use a patient safety evaluation system and health care providers that implement quality improvement mechanisms.

Source: Authors' analysis.

This brief reviews action taken by state-based marketplaces to implement the law's quality requirements, as well as other efforts to improve health care quality. It focuses on three areas: 1) selectively contracting only with insurers that advance marketplace goals by implementing quality and delivery system reforms; 2) informing consumers about health plan quality; and 3) collecting data to inform quality improvement. Thirteen state-based marketplaces took one or more of these steps in 2014. Some states with federally facilitated marketplaces also may be pursuing similar strategies, but this is outside the scope of this brief.[8] States are in different stages of progress. Some are opting for a more proactive approach, while others are deferring quality improvement efforts to focus on immediate operational issues, avoid requirements that might deter insurers from participating, or await further federal guidance. Efforts to drive quality improvement and broader payment and delivery system reforms through the marketplaces are still in their infancy and can be expected to evolve significantly in the future.[9]

FINDINGS

Promoting Quality Improvement and Delivery System Reforms

Thirteen state-based marketplaces took one or more steps to promote quality improvement and delivery system reforms through their marketplaces in 2014. Of these, four selectively contracted with health plans based on quality and value, nine publicly displayed or linked to quality information in 2014, and 11 took action to collect quality information from insurers (Exhibit 2).[10] Of the states reporting public quality data, eight used some form of a star rating system.

Exhibit 2. Summary of State Action on Quality Improvement and Delivery System Reforms, 2014

State	Using Selective Contracting Based on Health Plan Quality and Value	Publicly Reporting Quality Information on Marketplace Plans	Collecting Quality Information from Marketplace Insurers
California	X	X	X
Colorado	–	X	X
Connecticut	–	X	X
Kentucky	–	–	X
Maryland	–	X	X
Massachusetts	X	X	–
Nevada	–	–	X
New York	–	X	X
Oregon	–	X	X
Rhode Island	X	–	X
Utah	–	X*	–
Vermont	X	–	X
Washington	–	X	X

Notes: Quality information includes clinical quality and patient experience metrics as well as quality improvement strategy summaries.
* In Utah, the marketplace includes a link to quality reports but does not directly incorporate quality information in the overall display of health plan information. In addition, quality information is available only for the SHOP marketplace.
Source: Authors' analysis.

Using a Selective Contracting Approach

The Affordable Care Act granted states significant discretion in determining whether and how to approve plans that apply to be sold on their state marketplaces.[11] States can allow any plan meeting basic criteria to be sold on their marketplaces or can be more selective by approving only those health plans that meet criteria set by the state, such as the plan's ability to promote quality and value.[12] The latter approach is known as "selective contracting" or "active purchasing." In 2014, four states—California, Massachusetts, Rhode Island, and Vermont—adopted a selective contracting approach (Exhibit 3).[13]

Exhibit 3. State Approaches to Selecting Marketplace Plans for 2014

Plan Selection Approach	Definition	States
Selective contracting	State contracts only with insurers that advance marketplace goals; state may manage plan choices by limiting the number or type of plans that an insurer can offer.	CA, MA, RI, VT
Market organizer	State manages plan choices by limiting the number or type of plans that an insurer can offer but does not selectively contract with insurers.	CT,[a] KY, MD,[b] NV, NY, OR[c]
Clearinghouse	State allows all plans meeting minimum criteria to participate on the marketplace; state does not selectively contract with insurers or manage plan choices.	CO,[d] DC, HI, MN,[e] NM, UT, WA

Note: These data reflect state-based marketplace design decisions for policy or plan years beginning on or after January 1, 2014. These data do not identify the options that a state-based marketplace may be considering for future years. The federally facilitated marketplace operated as a clearinghouse in 2014.

[a] In Connecticut, the marketplace will contract with any carrier that meets the standards for qualified health plan (QHP) certification. Nothing precludes the marketplace from selectively contracting and not offering for sale one or more otherwise certified QHPs on the basis of price if there is an adequate number of QHPs available to allow for sufficient consumer choice.

[b] In Maryland, the marketplace has the authority to employ selective contracting strategies beginning in 2016.

[c] Oregon had legislative authority to pursue an active purchaser model but chose not to adopt this in 2014.

[d] Colorado law prohibits the marketplace from serving as an active purchaser.

[e] Minnesota's marketplace had statutory authority to pursue an "active purchaser" model beginning in 2015. In January 2014, the board for MNSure, Minnesota's health insurance marketplace, considered whether to pursue an active purchaser model in 2015 as allowed by law, but decided not to do so.

Source: Authors' analysis.

Marketplaces that used selective contracting evaluated and selected plans based on factors like affordability, use of team-based care, prevention and wellness programs, and participation in statewide payment reforms.[14] Massachusetts, for example, required insurers to develop plans to shift provider contracts from fee-for-service to risk-based payment models, like global or bundled payments.[15] Covered California—California's health insurance marketplace—evaluated and selected plans based on factors such as affordability, patients' access to high quality care, and efforts to reduce health disparities.[16]

Providing Public Information on Health Plan Quality or Consumer Satisfaction

Reporting on health plan quality can encourage consumers to select health plans with high scores on measures of quality and consumer satisfaction.[17] Under the Affordable Care Act, health plans sold on the marketplaces are not required to do so until 2016. However, nine states made quality or consumer satisfaction information for marketplace health plans publicly available this year (Exhibit 4). Of these, eight states made quality or consumer satisfaction data available directly on their marketplace web site, while one state, Utah, linked to external quality data.

Exhibit 4. State Action to Report Health Plan Quality Information to Consumers, 2014

State	Displayed Quality Data in 2014	Star Rating System	Quality Rating Score Metrics	Other Quality Information Displayed
Federally facilitated marketplace	–	–	–	–
California	X	4 stars	CAHPS	–
Colorado	X	5 stars	CAHPS	Accrediting agency, accreditation type, accreditation status, detailed ratings for those plans that are currently NCQA accredited, Consumer Complaints Index, free text section outlining quality improvement strategy, individual HEDIS metrics
Connecticut	X	4 stars	NCQA accreditation	–
District of Columbia	–	–	–	–
Hawaii	–	–	–	–
Kentucky	–	–	–	–
Maryland	X	5 stars	CAHPS, HEDIS, state-specific metrics	–
Massachusetts	X	4 stars	NCQA accreditation	–
Minnesota	–	–		–
Nevada	–	–	–	–
New Mexico	–	–	–	–
New York	X	4 stars	CAHPS, HEDIS, state-specific metrics	–
Oregon	X	4 stars	CAHPS, HEDIS	–
Rhode Island	–	–	–	–
Utah	X	3 stars	CAHPS	–
Vermont	–	–	–	–
Washington	X	–	–	Quality improvement strategy summary

Notes: The data reflect state-based marketplace design decisions and currently available information on state-based marketplace websites as of February 1, 2014. The data do not identify the options that a state-based marketplace may be considering for future years. For more detail on state public quality reporting strategies, see the Appendix. HEDIS = Healthcare Effectiveness Data and Information Set; NCQA = National Committee for Quality Assurance; CAHPS = Consumer Assessment of Healthcare Providers and Systems.

Source: Authors' analysis.

Beginning in 2016, all marketplaces will be required to display quality metrics using a federal quality rating system, developed by the U.S. Department of Health and Human Services, that aggregates multiple metrics into scores depicted as a star rating.[18] Most of the states displaying quality information in 2014 used a state-specific star rating system, though states differed in terms of data sources, numbers and types of metrics, and methodologies. Five states converted a single source of data—such as accreditation status or consumer satisfaction data—into a star rating, while three states—Maryland, New York, and Oregon—implemented comprehensive quality rating systems that incorporated multiple data sources (Exhibit 5).

Exhibit 5. Comparison of Selected Quality Rating System Structures

	Federally Facilitated Marketplace[a,b]	Maryland	New York	Oregon
Global rating	Five-star scale	Five-star scale	Four-star scale	Four-star scale
Summary ratings	• Clinical quality management • Member experience • Plan efficiency, affordability, and management	• HEDIS • CAHPS • Other state-specific metrics	–	–

Domains	• Clinical effectiveness
	• Patient safety[b]
	• Care coordination
	• Prevention
	• Access
	• Doctor and care
	• Efficiency and affordability
	• Plan services
		• Indicators of clinical performance (HEDIS)
		• Enrollee satisfaction measures (CAHPS)
		• Other state-specific metrics:
		  • Maryland Behavioral Health Assessment
		  • Maryland Health Plan Quality Profile
		  • Qualified Health Plan Focus on Cultural and Ethnic Diversity of Membership
			• Satisfaction
			• Children
			• Pregnancy
			• Adult health conditions[c]
				• Preventive care
				• Complex care
				• Patient experience

Composites	• Clinical effectiveness: behavioral health, cardiovascular care, diabetes care • Prevention: cancer screens, maternal health, adult health, child health • Access: access to preventive visits, composite scores of access to care • Doctor and care composite measure • Plan efficiency: efficient care, members' experiences with health plan	• HEDIS: women's health, primary care, and wellness for children and adolescents, behavioral health • CAHPS: rating of health plan, customer service composite score, getting needed care composite score • Behavioral Health Assessment: number of Maryland providers, network provider locations • Quality Profile: quality assurance and quality improvement initiatives • Race/Ethnicity, Language, Interpreters, and Cultural Competency (RELICC) survey: diversity of enrollees, provider network and carrier staff languages	–	–
Number and examples of individual metrics	42 metrics for adults, 25 for children[d] Examples: • Follow-up after hospitalization for mental illness • Controlling high blood pressure • Medication management for people with asthma (ages 5–18) • Childhood immunization status (child only) • Breast cancer screening	100+ measures of plan performance[e] Examples: • Well-child visits in the first 15 months of life • Child immunization services • Adolescent well-care visits • Human Papillomavirus vaccine (female adolescents) • Use of appropriate medications for people with asthma • Breast cancer screening	12 HEDIS and CAHPS measures Examples: • Rating of health plan • Immunization • Timeliness of prenatal care • Breast cancer screening • Advising smokers to quit	Examples: • Breast cancer screenings • Flu shots • Diabetes screenings • Avoidable hospital stays • Overall rating of health care

Notes: Reflects federal quality rating system and proposed New York quality rating system, as well as quality rating systems currently in use for marketplace plans in Maryland and Oregon. HEDIS = Healthcare Effectiveness Data and Information Set; CAHPS = Consumer Assessment of Healthcare Providers and Systems.

[a] In the proposed federally facilitated marketplace, the qualified health plan-specific quality rating will be available for display in the 2016 open enrollment period for the 2017 coverage year. The federally facilitated marketplace website, healthcare.gov, is not currently displaying quality metrics for participating plans.

[b] In the federal quality rating system, child-only measure sets do not include patient safety as a domain, but use the same three summary indicators as for adults (clinical quality management, member experience, and plan efficiency, affordability, and management).

[c] In New York, five domains provide information about categories of care; two domains focus on overall performance of Child Health Plus plans.

[d] The proposed federal quality rating system will use 42 total measures including 29 clinical measures and 13 CAHPS survey measures. The child-only quality rating system consists of 25 total measures, including 15 clinical measures and 10 CAHPS survey measures.

[e] Maryland does not have a separate child-only rating system.

Source: Authors' analysis.

States had strong interest in moving forward with quality reporting, but some chose instead to focus on immediate operational needs or proceeded in a more limited way than originally planned because of technical challenges.[19] California, for example, altered its original plan to display comprehensive quality ratings incorporating both clinical quality and consumer satisfaction data, partly because the best available performance information for the majority of plans participating in the marketplaces would have reflected significantly different products, provider networks, and populations than non-marketplace plans. Instead, for plan year 2014, California opted to display a simplified rating system encompassing 10 survey questions on consumer satisfaction based on services delivered in 2011.[20]

Reporting Quality Information to the Marketplace

Ongoing data collection and evaluation of health plan quality and costs will be critical to developing marketplace strategies aimed at improving quality and reforming the delivery system.[21] In 2014, 11 states required insurers to report quality information to their marketplaces to inform the 2014 plan selection and quality reporting process, as well as to aid future decision-making on quality initiatives (Exhibit 6). However, states varied in the level of specificity required. While most states required insurers to report measures from national data sets such as Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS), others required more extensive data reporting. California, for the initial plan selection and certification process, required insurers to submit detailed information on plan performance and quality improvement through the eValue8 survey, a value-based purchasing tool that collects standardized data on hundreds of quality and performance metrics.[22] Additionally, California requires insurers to submit HEDIS and CAHPS data for use in future comprehensive quality rating system development. Other marketplaces, such as those in Maryland, New York, and Vermont, drew on long-standing quality reporting requirements in their states.[23] California and New York specified that insurers should have adequate infrastructure to collect, report, and analyze health care quality data and carry out quality improvement activities.[24] In addition, eight states required insurers to provide a written report of their quality improvement strategies.

To maximize the effectiveness of quality and delivery system reform efforts and ease the burden of reporting requirements, marketplaces can align their quality improvement strategies, measurements, and programs with other payers.[25] Such efforts could be facilitated by statewide collection of cost, utilization, and other data through tools like all-payer claims databases.[26] Twelve of the study states have or are implementing such a database.[27]

DISCUSSION

Health insurance marketplaces are a potential vehicle for improving the quality and cost-effectiveness of care delivered to millions of people in the individual and small-group markets.[28] To do so, they must address the fragmentation that has previously characterized these markets by setting common, evidence-based standards and expectations for quality improvement, delivery system reform, and population health. Quality improvement efforts must overcome challenges like the need for effective IT systems, sufficient enrollment to make quality measurement statistically meaningful, selecting among the most effective quality measures and delivery system reforms, and technical complexities like lag times in data reporting and a lack of data for new plans in the market.

Exhibit 6. Health Insurance Marketplace Internal Reporting Requirements for 2014

State	Requiring Qualified Health Plans to Report Quality Information Beyond Accreditation Status to Marketplace in 2014[a]	Type of Quality Reporting Information			
		CAHPS	HEDIS	State-Specific Metrics	Quality Improvement Strategy[b]
Federally facilitated marketplace	–	–	–	–	–
California*	X	X	X	–	X
Colorado*	X	X	X	–	–[c]
Connecticut*	X	X	–	–	X
District of Columbia	–	–	–	–	–
Hawaii	–	–	–	–	–
Kentucky	X	–	–	–	X
Maryland*	X	X	X	X	–
Massachusetts*	–	–	–	–	–
Minnesota*	–	–	–	–	–
Nevada	X	–	–	–	X
New Mexico	–	–	–	–	–
New York*	X	X	X	X	X
Oregon*	X	X	X	–	X
Rhode Island*	X	–	–	–	X
Utah*	–	–	–	–	–
Vermont*	X	–	–	X	–
Washington*	X	–	–	–	X

* State has or is implementing an all-payer claims database (APCD). In Connecticut, the marketplace administers the APCD and an advisory group drafts the policies and procedures. New York's APCD will support the business operations of the marketplace, including providing the marketplace with quality and price data. Minnesota is prohibited by statute from using its APCD for purposes of developing quality metrics.

Notes: HEDIS = Healthcare Effectiveness Data and Information Set; CAHPS = Consumer Assessment of Healthcare Providers and Systems.

[a] Reflects reporting requirements in addition to the insurer's accreditation status, which is a required reporting requirement in all marketplaces.

[b] State requires a written narrative regarding the insurers' quality improvement strategy (QIS). States requiring issuers to attest to their QIS, without requiring reporting on its contents, were not included. In 2014, insurers must implement a QIS to reduce readmissions, improve health outcomes, and achieve other goals. In 2016, insurers must submit an annual report to HHS and to enrollees regarding whether benefits under the coverage or plan satisfy quality elements similar to those in the QIS.

[c] Insurers in Colorado must attest to having a QIS; a narrative is optional. If completed, the QIS will be displayed to consumers.

Source: Authors' analysis.

Health insurance marketplaces allow consumers to compare plans side by side based on variables like cost, benefits, and quality ratings. While there is some evidence that consumers use quality information to guide coverage decisions, there are also limitations to its usefulness, particularly in the initial years. Many consumers are navigating the complexities of selecting a private insurance plan for the first time this year, and are likely to be more focused on factors like premiums and cost-sharing.[29] Efforts to display public quality information also were hindered by the limitations of the marketplace information technology infrastructure during the 2014 open enrollment season. As a result, consumers lacked the tools to make plan choices informed by quality data. Because marketplace health plans are new entities that must build experience to accurately report on quality, and all states must

implement the federal quality rating system in 2016, consumers also should be educated on year-to-year differences in health plan quality scores. States can help consumers better understand the value and limitations of quality data by providing web-based decision-support software and clear explanations and by training call center staff, navigators, assisters, and brokers to answer consumers' questions. In addition, states can enhance the value of their public quality reporting by evaluating how consumers used available information to make purchasing decisions, and by considering additional features such as the ability to drill down to individual quality metrics.

A health insurance marketplace is just one of many purchasers and payers operating in an environment crowded with diverse quality measure sets and initiatives.[30] Although many states took action to display quality information to consumers in 2014, their efforts reflected a variety of methodologies, performance metrics, and data sources. While this diversity allows for innovation, the lack of alignment among goals and metrics can burden providers and insurers, dilute efforts to bring evidence-based reforms to their maximum potential, and make comparisons more challenging. Final regulations require states to display a federally developed quality rating system in 2016, while allowing them to also display their own metrics pursuant to forthcoming guidance.[31] State health insurance marketplaces will need to weigh the value of adding state-specific metrics to the federally required quality rating system, particularly if they have limited resources or other operational challenges.

Marketplace quality improvement efforts in most states have primarily focused on displaying data for consumers, with only a few states setting additional requirements for insurers' quality improvement efforts. Insurers may be encouraged to improve their performance simply because quality data is made public. But even the most robust public quality reporting system is limited in its ability to drive competition based on quality, partly because consumers will be comparing plans based on other factors, such as cost, covered benefits, and provider networks. Policymakers also will need to consider the infrastructure, such as information technology systems, needed by marketplaces and insurers to conduct quality improvement activities. A foundation of reliable, timely, and comparable performance data for all marketplace health plans will be essential for analyzing the effect of quality improvement efforts on outcomes and costs. It also will be critical in deciding on next steps—for instance, approving plans based on quality and performance or tying financial incentives to plan performance—which may further drive plans to compete on quality.

The Affordable Care Act offers state health insurance marketplaces a foundation for promoting quality improvement and delivery system reform and most state marketplaces are working toward these goals. Recent federal regulations requiring uniformity in quality reporting in all marketplaces also may help consumers compare plans based on quality, although it will be important to educate consumers on the differences between quality rating systems that states may be using this year and the federal system yet to be put in place. States' initial efforts offer an important learning opportunity for evaluating the effect of quality improvement initiatives in health insurance marketplaces on the delivery of high-quality care.

Methodology

This issue brief examines policy and design decisions made by the 16 states (California, Colorado, Connecticut, Hawaii, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New Mexico, New York, Oregon, Rhode Island, Utah, Vermont, and Washington) and the District of Columbia that chose to establish and operate a state-based individual or Small Business Health Options Program (SHOP) marketplace for 2014. Idaho's individual and SHOP marketplaces, along with New Mexico's individual marketplace, are operating as a "supported state-based marketplace" in 2014, borrowing the federal information technology infrastructure as the states build their own IT systems. Although not reviewed for purposes of this paper, states in which the federal government is managing the marketplace, including state-partnership marketplaces, have discretion over certain policy decisions affecting the operation of the marketplace in their state, including setting standards to promote quality and delivery system reforms.

Our findings are based on public information—such as state laws, regulations, subregulatory guidance, marketplace solicitations, and other materials related to marketplace development—and interviews with state regulators. Data on public quality metrics were confirmed, where possible, by browsing the available plan offerings on state marketplace websites. The resulting assessments of state action were confirmed by state officials. These features may change or be periodically unavailable as states continue to develop their marketplaces.

Appendix. State-Based Marketplace Action on Health Plan Quality Reporting, 2014

Marketplace	Public Quality Reporting for 2014
Federally facilitated marketplace	Did not publicly display health plan quality performance data in 2014. Beginning in 2016, all marketplaces must display quality data. Insurers must submit quality data beginning in 2015 to use in beta testing, but this will not be publicly reported.
California	Publicly displayed health plan quality performance data in 2014. Used a 4-star quality rating score reflecting 10 CAHPS measures based on services delivered in 2011. For initial plan selection and certification, California's marketplace also required insurers to report eValue8 scores. For recertification, California required completion of select eValue8 modules as well as commitments to provide additional potential quality metrics that could be reported on and measured in the future.
Colorado	Publicly displayed health plan quality performance data in 2014. Used a 5-star quality rating score reflecting health plans' response to the "overall rating of health plan" CAHPS question based on services delivered in 2011. Plans without a score were labeled "rating in progress."
Connecticut	Publicly displayed health plan quality performance data in 2014. Used 4-star quality rating score based on insurers' NCQA accreditation status converted into star rating, with 4 stars reflecting an "excellent" rating, 3 stars reflecting "commendable," 2 stars reflecting "accredited," and 1 star reflecting "provisional." If NCQA accreditation has not been achieved by a plan, "not yet rated" is displayed.
District of Columbia	Did not publicly display health plan quality performance data in 2014.
Hawaii	Did not publicly display health plan quality performance data in 2014.
Kentucky	Did not publicly display health plan quality performance data in 2014. Kentucky had initially planned to display a 5-star quality rating score based on NCQA accreditation in 2014, but did not do so.
Maryland	Publicly displayed health plan quality data in 2014. Used a 5-star quality rating score incorporating measures from CAHPS, HEDIS, and state-specific quality reporting systems based on services provided in 2012. These values are run through a formula created by the Maryland Health Care Commission in which the total scores are then given a star value, with 1 star representing the 0–10th percentile, 2 stars representing the 11th–25th percentile, 3 stars representing the 26th–50th percentile, 4 stars representing the 51st–75th percentile, and 5 stars representing performance above the 75th percentile.
Massachusetts	Publicly displayed health plan quality performance data in 2014. Used a 4-star quality rating system reflecting NCQA accreditation scores.
Minnesota	Did not publicly display health plan quality performance data in 2014, although it had plans to do so. Minnesota pursued, but did not implement, development of a state-specific quality rating system methodology in 2014.
Nevada	Did not publicly display health plan quality performance data in 2014.
New Mexico	Did not publicly display health plan quality performance data in 2014. In New Mexico, insurers are expected to begin reporting quality data to the marketplace in 2014.
New York	Publicly displayed health plan quality performance data in 2014. Used a 4-star quality rating score based on a combination of approximately 20 HEDIS and CAHPS measures. The New York State Department of Health displays "new plan quality data not yet available" for those plans without reportable quality data. The New York Office of Quality and Patient Safety is developing a quality rating system aggregated into five domains contributing to an overall rating for each insurer or product (i.e., type of health insurance, such as HMO or PPO). The five domains are consumer satisfaction, children's health, pregnancy care, adult health, and health conditions.
Oregon	Publicly displayed health plan quality performance data in 2014. Used a 4-star quality rating score incorporating CAHPS and HEDIS health plan performance measures in three domains: preventive care, complex care, and patient experience. Star rating is determined by comparing the insurers' scores on various metrics within these domains compared with the Oregon average, the national average, and the national 90th percentile. Four stars reflects performance above all three benchmarks, 3 stars reflects performance above two benchmarks, 2 stars reflects performance above one benchmark, and 1 star reflects that performance does not exceed any benchmarks.
Rhode Island	Did not publicly display health plan quality performance data in 2014, although it had plans to do so.
Utah	Linked to health plan quality performance data in 2014, but did not embed quality data in marketplace health plan display.
Vermont	Did not publicly display health plan quality performance data in 2014. All marketplace health plans must comply with existing state regulations for managed care organizations, including reporting to the state on HEDIS, CAHPS, and state-specific performance measures.
Washington	Publicly displayed quality improvement strategy summary, but not other performance data, in 2014. Washington expects to display quality measures, beyond the quality improvement strategy, as early as the 2015 open enrollment period for the 2016 plan year. Insurers are expected to begin reporting quality data to the exchange in 2014.

Source: Authors' analysis of regulations, public state documents, marketplace websites, and interviews with state regulators.

NOTES

1 See, e.g., Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century.* (Washington, D.C.: National Academies Press, March 2001).

2 See, e.g., Department of Health and Human Services, *2013 Annual Progress Report to Congress: National Strategy for Quality Improvement in Health Care,* (Washington, D.C.: U.S. Department of Health and Human Services, 2013); M. Burns, M. Dyers, and M. Bailit, *Reducing Overuse and Misuse: State Strategies to Improve Quality and Cost of Health Care,* (Princeton, N.J.: Robert Wood Johnson Foundation, Jan. 2014); K. Sebelius, "The Affordable Care Act at Three: Paying for Quality Saves Health Care Dollars," *Health Affairs Blog,* March 20, 2013, http://www.healthaffairs.org/blog/2013/03/20/the-affordable-care-act-at-three-paying-for-quality-saves-health-care-dollars/; Bailit Health Purchasing, L.L.C., *Facilitators and Barriers to Payment Reform: Market-Based, Governmental, Organizational, and Design Considerations* (Princeton, N.J.: Robert Wood Johnson Foundation, Sept. 2013); and National Committee for Quality Assurance, *State of Health Care Quality 2013* (Washington, D.C.: NCQA, Oct. 2013).

3 J. Volk and S. Corlette, *The Role of Exchanges in Quality Improvement: An Analysis of the Options*. (Washington, D.C.: Georgetown University Health Policy Institute, Sept. 2011).

4 Ibid.

5 45 C.F.R. §156.275, §155.1045, §155.200, §155.205.

6 Volk and Corlette, *Role of Exchanges in Quality Improvement,* 2011.

7 Center for Consumer Information and Insurance Oversight, *General Guidance on Federally Facilitated Exchanges* (Washington, D.C.: U.S. Department of Health and Human Services, CCIIO, May 16, 2012); Center on Consumer Information and Insurance Oversight, *Letter to Issuers* (Washington, D.C.: U.S. Department of Health and Human Services, CCIIO, April 5, 2013); and U.S. Department of Health and Human Services, *Request for Information Regarding Health Care Quality for Exchanges (CMS–9962–NC)* (Washington, D.C.: DHHS, Nov. 27, 2012).

8 See, e.g., Arkansas Insurance Department, *Bulletin No. 9-2014: 2015 Plan Year Requirements for Qualified Health Plan Certification in the Arkansas Federally-Facilitated Partnership Marketplace* (April 11, 2014).

9 See, e.g., S. Delbanco, "The Payment Reform Landscape: Pay-for-Performance," *Health Affairs Blog,* March 4, 2014, http://healthaffairs.org/blog/2014/03/04/the-payment-reform-landscape-pay-for-performance/; and C. L. Damberg, E. M. Sorbero, S. L. Lovejoy et al., *Measuring Success in Health Care Value-Based Purchasing Programs: Findings from an Environmental Scan, Literature Review, and Expert Panel Discussions* (Santa Monica, Calif.: RAND Corporation, 2014).

10 In Utah and Vermont the exchange will include a link to quality reports but will not incorporate quality information in the search function for Qualified Health Plans in 2014. In Utah, quality information is available in the SHOP marketplace only.

11 S. Dash, K. Lucia, K. Keith et al., *Implementing the Affordable Care Act: Key Design Decisions for State-Based Exchanges* (New York: The Commonwealth Fund, July 2013).

12 Volk and Corlette, *Role of Exchanges in Quality Improvement,* 2011; and Dash, Lucia, Keith et al., *Implementing the Affordable Care Act: Key Design,* 2013.

13 Dash, Lucia, Keith et al., *Implementing the Affordable Care Act: Key Design,* 2013.

14 Vermont Health Connect, *Request For Proposals: Selection of Qualified Health Plans* (Williston, Vt.: Vermont Health Connect, Dec. 21, 2012); Covered California, *Qualified Health Plan Contract for 2014* (Sacramento, Calif.: Covered California, July 3, 2013); and Rhode Island Executive Order 11-09, Sept. 19, 2011 §11; 33 VSA Sec. 1806(a).

15 In Massachusetts, participating insurers must work with the Health Connector to develop a specific plan to transition its provider contracts over a defined time frame, with the specific goal being that at least 25 percent of its membership would be covered under provider contracts based

on alternative payment models. Alternative payment models include methods of payment that are not solely based on fee-for-service reimbursements including, but not limited to, shared-savings arrangements, bundled payments, and global payments. Alternative payment methodologies may also include fee-for-service payments, which are settled or reconciled with a bundled or global payment.

16 Covered California, *Addressing Health Equity and Health Disparities* (Sacramento, Calif.: Covered California, Jan. 21, 2013).

17 J. Hoadley, "Performance Ratings and Plan Selection by Medicare Beneficiaries," *Journal of the American Medical Association,* Jan. 16, 2013 309(3):287–88.

18 U.S. Department of Health and Human Services, *Draft Quality Rating System Scoring Specifications* (Washington, D.C.: DHHS, March 2014); and U.S. Department of Health and Human Services, *Proposed Patient Protection and Affordable Care Act; Exchanges and Qualified Health Plans Quality Rating System (QRS), Framework Measures and Methodology* (Washington, D.C.: DHHS, Jan. 2014).

19 Personal correspondence with state officials, California, Connecticut, District of Columbia, Kentucky, Maryland, Minnesota, Rhode Island, Vermont (May 2013; on file with authors).

20 Covered California, *Memorandum: Health Plan Quality Rating Systems for 2013*, (Sacramento, Calif.: Covered California, Aug. 2, 2013); Covered California, *Covered California Exchange Board Meeting Minutes* (Sacramento, Calif.: Covered California, Nov. 21, 2013); and Covered California, *Covered California Executive Directors Report* (Sacramento, Calif.: Covered California, Aug. 22, 2013).

21 C. Miller and A. Arons, *A Vision for Quality Data Infrastructure to Support Health System Transformation* (Portland, Maine: National Academy for State Health Policy, June 2013), http://www.nashp.org/publication/vision-quality-data-infrastructure-support-health-system-transformation.

22 National Business Group on Health, About eValue8, http://www.nbch.org/eValue8; and Covered California, *QHP Issuer 2015 Renewal Application* (Sacramento, Calif.: Covered California, draft Jan. 2013).

23 Personal correspondence with exchange official, New York Health Benefit Exchange (May 15, 2013) (on file with authors); and personal correspondence with exchange official, Vermont Health Benefit Exchange (May 14, 2013) (on file with authors).

24 California Health Benefit Exchange, *2012–2013 Initial Qualified Health Plan Solicitation to Health Issuers and Invitation to Respond, Redline Version: Companion to QHP New Entrant Application for Plan Year 2015 Draft, January 23, 2014* (Sacramento, Calif.: Covered California, Jan. 2014); and Office of the New York Health Benefit Exchange, *Invitation to Participate in the New York Health Benefit Exchange, January 31, 2013* (Albany, N.Y.: New York State Department of Health, Jan. 31, 2013).

25 Volk and Corlette, *Role of Exchanges in Quality Improvement,* 2011.

26 J. Porter, D. Love, A. Peters et al., *The Basics of All-Payer Claims Databases: A Primer for States* (Princeton, N.J.: Robert Wood Johnson Foundation, Jan. 2014).

27 Ibid.; and authors' analysis.

28 J. Banthin and S. Masi, *Updated Estimates of the Insurance Provisions of the Affordable Care Act* (Washington, D.C.: Congressional Budget Office, March 4, 2014).

29 C. H. Monahan, S. J. Dash, K. W. Lucia et al., *What States Are Doing to Simplify Health Plan Choice in the Insurance Marketplaces* (New York: The Commonwealth Fund, Dec. 2013).

30 A. Higgins, G. Veselovskiy, and L. McKown, "Provider Performance Measures in Private and Public Programs: Achieving Meaningful Alignment with Flexibility to Innovate," *Health Affairs,* Aug. 2013 32(8):1453–61.

31 45 C.F.R. §155.1400, §156.1120; and U.S. Department of Health and Human Services, *Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond: Final Rule* (Washington, D.C.: DHHS, May 2014).

About the Authors

Sarah J. Dash, M.P.H., is a research fellow at the Georgetown University Health Policy Institute's Center on Health Insurance Reforms and vice president for policy at the Alliance for Health Reform. At Georgetown, her principal research focus has been comprehensive monitoring of state health insurance exchange implementation and the intersection of public and private health insurance with delivery system reforms. Previously, she was a senior health policy aide on Capitol Hill. Ms. Dash earned her master's degree in public health from Yale University.

Sabrina Corlette, J.D., is a senior research fellow and project direcotr at the Georgetown University Health Policy Institute's Center on Health Insurance Reforms. Her areas of focus include state and federal regulation of private health insurance plans and markets, and implementation of new rules for insurance markets under the Affordable Care Act. She serves as a consumer representative to the National Association of Insurance Commissioners, and was appointed to its Consumer Information Workgroup. Ms. Corlette received her law degree from the University of Texas at Austin.

Amy Thomas is assistant director of plan support at the Association of Community Affiliated Plans. Previously Ms. Thomas was a research associate at Georgetown University Health Policy Institute's Center on Health Insurance Reforms. Before her tenure at Georgetown she worked at MDwise, a Medicaid managed care organization, where she managed the company's qualified health plan applications for Indiana's health insurance marketplace.

Editorial support was provided by Deborah Lorber.

The
COMMONWEALTH
FUND

www.commonwealthfund.org