Data Collection and Use in the New Health Insurance Marketplaces

Taylor Burke, JD, LLM[1]
Lara Cartwright-Smith, JD, MPH[2]
Sara Rosenbaum, JD[3]

Introduction

Implementation of the 2010 health reform law, the Patient Protection and Affordable Care Act (ACA), is in full swing with the recent opening of state and federally-facilitated health insurance marketplaces (a.k.a. exchanges) where individuals and small businesses can purchase health insurance plans from participating companies. Coupled with the many insurance market reforms under the ACA, the creation of the new regulated health insurance marketplaces may have far-reaching effects on the content, quality, and price of health plans sold in the small group and individual markets because new regulations require these marketplaces to create structures and processes to ensure the overall quality and value of plans sold. These processes include data reporting requirements for plans sold in marketplaces that will result in the provision of significant information to the marketplaces themselves, quality accreditation entities, HHS, and the public. Through the process of "certifying" and "accrediting" health plans as qualified to be sold in the new marketplaces, as discussed below, information about health insurance policies, practices, cost, and quality that was not previously required to be reported will now be disclosed.

Under the ACA, insurers seeking to sell plans in the marketplaces (whether state-based, partnership, hybrid or fully federally facilitated marketplaces) must pass a two-part test before any products can be listed for sale. First, each health plan must be certified as a "Qualified Health Plan" (QHP) by the applicable marketplace, with certification criteria spelled out in federal regulation[4] and supplemented by any additional standards that may be imposed under state law. Second, QHPs are required to meet quality accreditation standards and must implement a quality improvement strategy. Because it is not feasible to independently accredit every single QHP, the regulations instead require each product type offered by a QHP issuer (e.g., Marketplace HMO, Marketplace point of service (POS), Marketplace PPO) to be periodically reviewed and accredited by a quality accreditation entity recognized by HHS.[5]

Both steps require the collection of information from insurers, which is expected to result in greater public availability of health plan performance data. Taken together, these two new

[1] Associate Professor, Department of Health Policy, George Washington University School of Public Health and Health Services.
[2] Assistant Research Professor, Department of Health Policy, George Washington University School of Public Health and Health Services.
[3] Hirsh Professor of Health Law and Policy, Department of Health Policy, George Washington University School of Public Health and Health Services.
[4] 45 C.F.R. Parts 155 and 156.
[5] 45 C.F.R. § 156.275(a).

data reporting requirements – certification and quality accreditation – have the potential to improve the quality of marketplace health insurance products, since issuers will be subject to quality measurement at two points: prior to the time that their products are sold (certification) and periodically (as established by each marketplace) through performance reviews (quality accreditation). Importantly, many of the results of this two-pronged data review, along with some of the data elements themselves, will be posted on the marketplace websites for consumers to use in selecting plans.[6]

Data Collection to Support QHP Certification (Step 1)

QHPs must be certified initially as the marketplaces come online, and then periodically thereafter on a recertification schedule as set by the applicable marketplace. The minimum certification requirements cover categories such as the adequacy of a plan's provider network, its status as a licensed plan, whether its benefit design (i.e., what the plan covers) meets federal and state standards including coverage of essential health benefits, whether the plan is in compliance with marketing restrictions, whether the plan includes essential community providers, how the plan will implement applicable quality improvement standards, and whether the plan meets requirements related to the transparency of coverage.[7] In addition to ensuring that health insurers comply with these minimum requirements, marketplaces must also determine that certification (and recertification) of any particular health plan is in the best interest of qualified individuals and employers.[8]

Thus, in order to achieve QHP certification, an insurer must submit certain data to HHS, the marketplace, and the state insurance commissioner. HHS has outlined 13 categories of QHP certification data that issuers must report, shown in **Table 1**.

Table 1

Data Categories for QHP Certification[9]
Issuer Administrative Data Elements: Basic information required to identify issuers and the exchange markets they intend to serve, and to facilitate communications with and payment to issuers. The data elements may include issuer contact information and banking information.
State Licensure Documentation: Documentation necessary to demonstrate that an issuer is licensed and has authority to sell all applicable products in all states in which it intends to offer a QHP.
Documentation of Good Standing: Documentation necessary to demonstrate that an issuer is in compliance with all applicable state solvency requirements and other relevant state regulatory requirements.
Network Adequacy Data Elements: Documentation necessary to demonstrate compliance with state network adequacy rules or, in the absence of such standards, documentation necessary to demonstrate that an

[6] 45 C.F.R. § 155.205(b).
[7] 45 C.F.R. § 156.200 – 156.270.
[8] 45 C.F.R. § 155.1000(c).
[9] Agency Information Collection Activities; Proposed Collection; Comment Request; Webinars, 77 Fed. Reg. 69846, Supporting Statement for Initial Plan Data Collection to Support QHP Certification and other Financial Management and Exchange Operations, p. 3-4.

issuer has an adequate range of providers for the intended service areas.
Essential Community Provider (ECP) Data Elements: Number of participating Essential Community Providers participating in an issuer's provider network or other documentation necessary to demonstrate that that an issuer has an adequate range of ECPs for the intended service areas.
Accreditation Data Elements: If applicable, an issuer must provide certain data elements about accreditation conducted by a recognized accrediting entity. Issuer must also authorize the release of accreditation survey data to an exchange.
Service Area: Information identifying a plan's geographic service area.
Additional Supporting Documentation: Additional documentation required by the exchange for oversight purposes such as a compliance plan and organization chart.
Benefits and Associated Cost Sharing and Limits: Data necessary to describe benefits offered by a plan including covered services, co-payments, coinsurance, tiers, intervals, and limits.
Summary of Benefits and Coverage Data Reporting Requirements: Data elements necessary to create the Summary of Benefits and Coverage scenarios for display on the exchange website.
High-level Plan Data: Basic plan- level information for plans and products including information necessary for in-network and out-of-network deductibles and maximum out-of-pocket cost by benefit category.
Formulary Information including Tiers and Classes: Formulary information including pricing tiers, co-insurance, co-payment information, drugs included in the formulary, formulary version number, and its effective date.
Premium Rating Information and Business Rules: This information, related to the financial underpinnings of health insurance operations, incorporates rating tables, rating factors, and business rules required to perform rate review. It is needed in order to populate the premium calculator and perform calculations for risk adjustment.

In order to ease this data submission and collection, HHS has launched an effort to develop QHP data submission interfaces that are "very similar, if not identical" in order to ensure the data need only be submitted once.[10] HHS has set forth four data sets that will be collected by regulators for QHP certification, but not subject to public disclosure:[11]

- **Rate Review Data Elements:** Rate review information encompasses financial information that is specific to markets and products and necessary for QHP rate review as well as evaluation of cost-sharing reduction payments. This financial information could include: base period claims experience, projected period medical trend factors, and projected period administrative factors.
- **EHB and Additional Coverage Data including Allocation of Premium Information:** These data must be collected in order to determine how each plan proposes to allocate member premiums across the classes of essential health benefits (EHB) required under the law, as well as services and benefits covered in excess of the classes of benefits covered by the EHB standard. The EHB service classes are shown below in Table 2.
- **Cost-Sharing Reduction Advance Payments and Justification:** Data to support federal cost sharing reduction payments that make coverage more affordable for lower income individuals and families. This information also will support analysis of how

[10] 77 Fed. Reg. 69846, Supporting Statement, p. 2.
[11] 77 Fed. Reg. 69846, Supporting Statement, p. 4.

cost-sharing varies among silver-level QHPs, the level of coverage to which premium subsidies are pegged.

- **Actuarial Memorandum:** Actuarial information is needed to evaluate the appropriateness of plan rates. The information sought includes actuarial narrative and certification documents relevant to rate reviews, premium allocation for advance payments of the premium tax credits, and cost sharing reduction payments.

Marketplaces will use this information to determine whether, based on available data, offering the health plan would be in the best interest of the individuals and employers who will seek coverage through the marketplace.

Ongoing Quality Accreditation of QHP Product Type (Step 2)

In addition to initial certification of the QHPs, QHP issuers must be periodically accredited for quality by an HHS-recognized accrediting entity that reflects a variety of quality standards such as access, consumer satisfaction and clinical quality among others. Because independently accrediting each QHP in every marketplace seemed to restrictive, and accrediting at the insurance holding company level seemed too broad, the implementing regulations strike a balance by requiring accreditation based on local performance of its QHPs at the "product type" level.[12] HHS defines product as "a package of benefits that an issuer offers that is reported to state regulators in an insurance filing," as compared to a specific plan which is defined as "the discrete pairing of a package of benefits and a particular cost sharing option." Therefore, accreditation takes place at the product type level (e.g., Marketplace HMO, Marketplace point of service (POS), and Marketplace PPO) and not at the individual QHP level.

Indeed, an issuer may offer multiple QHPs under the same product type, in the same Marketplace (e.g. bronze HMO, silver HMO, gold HMO, platinum HMO) if the product type for that Marketplace is accredited. Accreditation is to be based on representative data for each QHP in that marketplace product type that is submitted by the issuer and that reflects the population enrolled.[13] Accreditation is designed to assure that in addition to the general certification standards applicable to insurers overall, the specific product types they offer in specific localities perform well.[14]

The accreditation review in part is based on an evaluation of performance in nine separate categories: adherence to clinical quality measures; patient experience ratings using a standardized patient survey instrument known as the Consumer Assessment of Healthcare Providers and Systems (CAHPS); consumer access to services; utilization management; quality assurance; provider credentialing; complaints and appeals; network adequacy and access; and

[12] 45 C.F.R. § 156.275 (c)(2)(iii). See also Patient Protection and Affordable Care Act; Data Collection to Support Standards Related to Essential Health Benefits; Recognition of Entities for the Accreditation of Qualified Health Plans, 77 Fed. Reg. 42658, 42665.
[13] Patient Protection and Affordable Care Act; Data Collection to Support Standards Related to Essential Health Benefits; Recognition of Entities for the Accreditation of Qualified Health Plans, 77 Fed. Reg. 42658, 42665.
[14] 45 C.F.R. § 156.275.

patient information programs.[15] The QHP product type must maintain accreditation as long as it is sold in the marketplace.

Clinical quality measures represent one of the nine categories of information to be evaluated for accreditation. The accrediting bodies will themselves fashion their clinical quality measures, but HHS has set forth 5 criteria that must be used in measurement design:

1. The measures must span a breadth of conditions and domains including, but not limited to, preventive care, mental health and substance abuse disorders, chronic care, and acute care;
2. The measures must include a mix of adult and pediatric quality indicators;
3. The measures must align with the priorities of the National Strategy for Quality Improvement in Health Care[16] and the National Quality Strategy: 2012 Annual Progress Report,[17] adopted under the ACA;
4. The measures must be either developed or adopted by a voluntary consensus standards setting body. Where endorsed measures are unavailable, the measures must be in common use in health plan quality measurement and must meet health plan industry standards; and
5. The measures must be evidence-based.[18]

These 5 criteria shed light on the actual performance measures that accrediting bodies will use and report on, although the precise measures (e.g., early entry into prenatal care; proportion of patients with hypertension whose conditions are under control) cannot be known until the reporting actually begins. At the same time, the potential scope of measurement is somewhat narrowed given the requirements that measures be endorsed or in common use and be evidence-based.[19]

The accreditation regulation requires accrediting entities to share their accreditation information with the marketplaces.[20] The accrediting entities must report as to whether a specific QHP issuer's product type has been approved as high quality. The entity must also submit data on accreditation status, the accreditation score and its expiration date, the clinical quality measure results, the CAHPS survey results, and a summary of all findings.[21] The rule specifies that the final quality ratings assigned through the accreditation process for each QHP issuer product type must be posted on the marketplace website for consumers to use in selecting their plans.[22] These requirements can be expected to result in significant and fairly consistent

[15] 45 C.F.R. § 156.275(a)(1).
[16] http://www.healthcare.gov/law/resources/reports/quality03212011a.html
[17] http://www.healthcare.gov/news/factsheets/2012/04/national-quality-strategy04302012a.html
[18] 45 C.F.R. § 156.275(c)(2)(ii)).
[19] Persons interested in seeing examples of endorsed measures or measures in common use should consult the National Committee for Quality Assurance http://www.ncqa.org, the National Quality Forum http://www.qualityforum.org/Home.aspx, and URAC https://www.urac.org.
[20] 45 C.F.R. § 156.275(c)(5).
[21] 45 C.F.R. § 156.275(c)(5)); See also 45 C.F.R. § 156.275(a)(2).
[22] 45 C.F.R. § 155.205(b)(1)(v).

information about performance across all plan products, particularly performance measures related to networks and clinical quality.

Conclusion

The QHP certification, recertification, and periodic accreditation processes hold important implications for patients, consumers, and the public. While certain information related to QHP certification and accreditation will remain subject to regulatory submission requirements only, much information from the certification and accreditation process will be made public.[23] Table 2 shows the information that will be publicly accessible to consumers through marketplace websites as a result of the two reporting processes.

Table 2

Information to be Posted on Exchange Website
Standardized and comparative information on QHP premiums and cost-sharing
Standardized and comparative summaries of QHP benefits and coverage
Identification of whether the QHP is a bronze, silver, gold or platinum plan
Results of the enrollee satisfaction surveys
Quality ratings assigned through the accreditation process
Medical loss ratio information
Transparency in coverage measures as reported by the QHPs • claims payment policies and procedures • periodic financial disclosures • data on enrollment, disenrollment, and the number of claims that are denied • data on rating practices • information on cost-sharing and payments with respect to any out-of-network coverage • information on enrollee rights
QHP provider directory
Information about navigators

The certification and accreditation requirements for plans sold in the new health insurance marketplaces represent major advances in the transparency of health plan information for patients and consumers.

[23] 45 C.F.R. § 155.205(b).