

## New Health Insurance Exchanges Expected to Address the Health Care Iron Triangle

Expanding access to health care is a primary goal of the Patient Protection and Affordable Care Act (PPACA), the landmark health reform legislation enacted in March 2010. Based in part on the reform model ratified by Massachusetts in 2006, this federal policy enterprise expands access to coverage using four main mechanisms: an individual mandate; expanding Medicaid eligibility; reconfiguring of commercial health insurance market rules; and establishing state-based health insurance exchanges (Exchange) that are set to open for business by 2014.<sup>1</sup>

Modeled after Stanford economist Alain Enthoven's theory of managed competition,<sup>2</sup> Exchanges are structured marketplaces where insurers compete on quality and value. Certain individuals will access premium subsidies and employees are offered a choice of health benefit designs, health insurance carriers, and provider networks. For small businesses in particular, Exchanges offer additional value beyond providing employees with choice. Typically, the small business owner works directly with their health plan to solve claims issues and enroll new employees into the insurance arrangement, among other administrative tasks. But in an Exchange, "back-office" administration of health benefits lies with the Exchange, a dynamic that promotes economic development by empowering employers to focus more resources on achieving their business goals rather than on health care.

Exchanges though, are expected to be more than merely a health insurance distribution apparatus. Policymakers envision Exchanges aggressively addressing the two other vertices of the iron triangle of health care – cost and quality – by serving as a vehicle through which states drive homegrown health reform efforts. Vermont's ongoing effort to introduce a single-payer health care system by leveraging their Exchange as the single point of entry for most health care in the state is a worthy example.<sup>3</sup>

To be certified by and subsequently offered in an Exchange, a qualified health plan (QHP) must satisfy not only traditional insurance regulatory requirements such as provider network adequacy and financial solvency, but myriad quality criteria as well. These include publicly reporting patient experience survey data and meeting minimum criteria on clinical and patient performance measures such as the Healthcare Effectiveness Data and Information Set (HEDIS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys.<sup>4</sup> Certified health plans must also implement a quality improvement strategy that leverages, "quality reporting, effective case management, medication and care compliance initiatives" and medical home models.<sup>5</sup> Other initiatives related to reducing hospital readmissions, improving patient safety, reducing medical errors, and implementing wellness and health promotion activities must also be undertaken by QHPs.<sup>6</sup> Beginning in 2015, most hospitals in each QHP's provider network will be required to utilize a patient safety evaluation system and have in place a comprehensive hospital discharge program that seeks to address the issue of transitions of care.<sup>7</sup>

One central decision transferred to each state under PPACA is whether to devise and implement its own Exchange.<sup>8</sup> For example, deferring this responsibility to the federal government could further complicate Pennsylvania's already complex health care and insurance systems, disrupt coordination with other state-based health programs, and discourage stakeholders from engaging in collaborative efforts that seek to improve patient outcomes. Principally citing a desire to keep health care truly a local endeavor, the majority of states, including Pennsylvania, will likely establish their own Exchange. The final report of the Pennsylvania Health Care Reform Advisory Committee – a multi-stakeholder workgroup – recommends that the state

establish its own Exchange, and that this new marketplace be structured as an independent public authority or a regulated non-profit entity and compete in the marketplace as an active purchaser, a model whereby it actively negotiates with health plans to garner high-value plans for its individual and small employer constituents.<sup>9</sup>

Making these recommendations a reality requires a change in state law by the General Assembly. Anthony M. Deluca, the Democratic Chair of the House of Representatives' Insurance Committee, is sponsoring H. 627, a bill that would establish the Pennsylvania Health Insurance Exchange and provide it with the powers and duties necessary to carry out its mandates.<sup>10</sup> As of the submission of this article, H. 627 was awaiting action by the House Insurance Committee.

Although the federal reform law focuses principally on expanding access, the states and private sector actors must not lose focus on the imperative to control costs and improve quality. While framed as bodies designed to address health care access issues, Exchanges more notably hold great promise in promoting visionary efforts aimed at mitigating costs and elevating quality. Indeed, qualifying these new marketplace arrangements simply as insurance delivery mechanisms will likely cause states to fall short of achieving the dual goals of better health and affordable care for all. In addition to streamlining health benefits administration and simplifying the health insurance shopping experience, Exchanges will endure as entities that accelerate the adoption of proven effective innovative care systems that lead to improved outcomes, lower costs, and greater overall value. ■

**Shawn Nowicki, MPH**  
*Director, Health Policy*  
*Northeast Business Group on Health and HealthPass New York*

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