

THE CAA AND HEALTH CARE QUALITY

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INTRODUCTION

Since the 1940s, access to health insurance has largely been governed by employers and other group purchasers, such as “Taft-Hartley” plans run by unions. Approximately 50% of the American population is covered by group health coverage.ⁱ Health care is the second largest expense after payroll for most companies and is crucial to the overall recruitment and retention of employees, as well as to their health, safety, and productivity.

The federal government treats purchaser investment in health benefits as tax-free compensation and regulates it under a 1974 federal law called the Employee Retirement Income Security Act of 1974 (ERISA). A new law amending ERISA was signed in 2020 and is now in effect with broad implications for purchasers, employees, and the health care industry: The Consolidated Appropriations Act of 2021 (CAA). The CAA clarifies certain fiduciary obligations under ERISA, significantly enhancing existing employer accountability for cost-effectiveness, quality, and value of health benefits. This paper focuses on one of the critical issues for employer compliance with the new law: employer responsibility for the quality of health care services offered to plan participants. The actions employers take may have significant implications for the broader health care industry including direct providers of health services in the post-CAA world.

Health plans should provide access to quality-of-care data and participants should be incentivized to use that data to seek the best care available at the most reasonable price.

THE CAA CLARIFIES AND, IN SOME CASES, CHANGES HOW HEALTH BENEFITS ARE REGULATED

Small businesses typically offer employee health benefits by purchasing an insurance product and paying premiums to a health insurance company. This is called a fully insured health plan, under which the insurer assumes the risk of providing health benefits for eligible expenses. The majority of employers with 200 or more employees are “self-insured”, meaning they offer self-funded health plans under which they assume all of the financial risks. Employers offering self-funded health benefits pay all eligible health care claims, typically contracting with a third-party administrator (TPA) to process and administer claims and issue payments to providers. In both cases, the investment in health benefits is tax-exempt compensation to employees.

Self-insured employer coverage is governed by ERISA, the same federal law that governs retirement benefits such as 401K plans and pension plans. ERISA sets minimum national standards for most voluntarily established retirement and health plans. ERISA requires that employers and other entities that administer plans and control plan assets, called “plan fiduciaries”, act prudently and “solely in the interest of participants and their beneficiaries” and “for the exclusive purpose” of providing benefits and defraying reasonable plan expenses.ⁱⁱ ERISA also prohibits payments to service providers unless the fees are reasonable.ⁱⁱⁱ

Over the decades, a large industry of service providers has emerged to support employers in carrying out their duties under ERISA. Unfortunately, when it comes to health benefits, too often those service providers do not disclose enough information to assure accountability to plan sponsors or allow for plan sponsors to effectively monitor their performance. Too often TPAs withhold from the employer the claims data generated when administering the plan, as well as the negotiated network rates and other cost and fee considerations. In addition, service providers often fail to disclose information reflecting their direct and indirect compensation, which could lead to a conflict of interest that negatively impacts the value of health benefits.

The new CAA language amends ERISA to solve these longstanding challenges and applies to fully insured and self-funded health plans. The CAA takes longstanding retirement plan compensation disclosure requirements^{iv} and expands them to health benefits plans, requiring, among other things, health plan fiduciaries to ensure that service provider compensation disclosures have been made. The CAA also prohibits gag clauses in service provider contracts which have been used to limit the ability of plans to obtain their own claims information and requires a plan fiduciary to submit an attestation to the Department of Labor (DOL) that such clauses have been removed from all their contracts with service providers. In addition, plans are now required to provide cost-sharing information to participants and to disclose in-network provider rates, historical out-of-network allowed amounts and the associated billed charges, and the negotiated rates for prescription drugs. These provisions, together with recently issued hospital transparency regulations requiring hospitals to disclose their rates and other provisions contained in the CAA, the Transparency in Coverage Final Rule, and the provisions of the No Surprises Act (NSA), create the conditions for full transparency and better value from health benefits. Employers are directly accountable for evaluating their existing service provider contracts to determine whether they are being operated in the best interest of plan participants, which empowers them to require the information and tools they need from vendors. This paper will focus on one of the least discussed aspects of employer compliance with the new law: employer responsibility for impacting the quality of health care services plan participants' access.

ARE EMPLOYERS REQUIRED TO FOCUS ON QUALITY OF CARE UNDER THE CAA?

ERISA already imposes significant requirements on plan sponsors for addressing quality of care, and those standards have been strengthened with the passage of the CAA. The DOL, which enforces ERISA, stated more than 20 ago that quality of service is a factor in selecting and monitoring a health plan service provider and that “a plan fiduciary’s failure to take quality of services into account in the selection process would constitute a breach of the fiduciary’s duty under ERISA.”^v According to DOL, a responsible health plan fiduciary “must engage in an objective process designed to elicit information necessary to assess the qualifications of the provider, the quality of services offered, and the reasonableness of the fees charged in light of the services provided.”^{vi} This process includes an evaluation of (a) the qualifications of those who will be providing medical services; (b) ease of access to medical providers and information about the health care provider’s operations; (c) the procedures

in place to timely consider and resolve patient questions and complaints; (d) the procedures for patient record confidentiality; and (e) enrollee satisfaction statistics.^{vii}

DOL, in conjunction with the Departments of Treasury and Health and Human Services (HHS) (collectively, the Departments), recently reiterated that the quality of health care services provided under a group health plan is an important component of overall plan value when they jointly issued the new Transparency in Coverage rule at the same time the CAA was being negotiated by Congress. The Departments noted in the rule's preamble that government agencies and the private sector have been working to provide quality information to consumers and that "once pricing data is available through the final rules, existing quality data can be considered with pricing data to produce a more complete and accurate picture of total value."^{viii}

While no court has yet had occasion to determine whether group health plan fiduciaries have a fiduciary duty under ERISA to provide information related to quality of care to health plan participants, DOL's repeated instruction to ERISA plans that quality of health care services is important, as well as the strong language in CAA heightening that standard (e.g., the CAA amended ERISA to add Section 724, which prohibits group health plans from entering into agreements that directly or indirectly restrict the plan from providing specific quality-of-care information about specific providers), suggest the time has come. Fiduciaries should make it a priority to facilitate informed decision-making for plan participants when it comes to accessing healthcare providers and facilities. At a minimum, even prior to enforcement or potential court actions, plan sponsors that demonstrate diligence in monitoring quality and disclosing comparative quality information to beneficiaries will likely minimize such risks.

Current regulatory guidance on specific standards for complying with the CAA is limited, but plan sponsors are still accountable and subject to the authority of DOL regulators as well as the courts for adhering to the spirit of the law. Plan sponsors seeking guidance should look to already-developed laws applicable to fiduciaries of retirement plans choosing investment options and service providers. It is well settled that retirement plan fiduciaries must have a prudent process in place for choosing investment options and service providers based on an evaluation of the costs, fees, risks, and investment performance, all of which have a direct impact on the amount of money available to employees upon retirement. Courts uniformly hold that fees paid for overpriced and poor performance are not reasonable and cannot meet the exclusive benefit requirement or the reasonableness requirement necessary to exempt compensation payments to service providers from the prohibited transaction rules. Retirement plan fiduciaries who do not pay close attention to investment options cost and performance are at substantial risk of litigation by unhappy plan participants and are personally liable for the losses resulting from their failure to do so.

Similarly, health plan fiduciaries must have a prudent process in place to evaluate the performance and costs of their health plan options, as well as a fiduciary process for retaining and monitoring service providers to those plans. Employers should establish management structures to run their health plans similar to the structures they have in place to run their retirement plans.

Like the benchmarks retirement plan fiduciaries establish to gauge whether plan investment options will provide enough retirement income for participants, health plan fiduciaries should establish measures to gauge whether their health plan is providing participants with valuable health care in terms of quality outcomes and cost-effectiveness. If they do not have the expertise to do so themselves, they must hire experts to advise them.

Still, in the past a fiduciary seeking to evaluate the value of a fee-for-service PPO was likely to encounter significant resistance from a TPA or other vendor asked to provide detailed information concerning the quality of care delivered by providers covered (or excluded from) the PPO network. Typically, insurers and TPAs providing access to networks do not emphasize the quality of network providers but instead, emphasize the breadth of the network and the price per unit of services they offer. The transparency requirements in the CAA support the position that non-disclosure of cost *and* quality information is outside the boundaries of the law and holds plan sponsors accountable for either acquiring the information or reporting failures to comply.

Due diligence by health plan fiduciaries requires that both price and quality be evaluated independently. Poor quality is one of the foremost “red flags” for a fiduciary standard because the absence of quality makes price irrelevant for patients and their loved ones. Negotiating a good price for bad health care does not fulfill the fiduciary obligations of prudence and loyalty. Moreover, quality—or its absence—is a major factor in determining the cost of care even if it is not correlated with the pricing of individual services. For instance, a hospital may offer lower prices, but if hospital-acquired infections are high, that will increase total patient costs by lengthening inpatient stays, necessitating new treatments, prompting readmissions, and requiring long-term follow-up care from community physicians.

Health equity is an additional aspect of quality of care, and one that is ripe for class action litigation in the future, so employers should seek out and report quality data that accounts for disparities in outcomes and/or other patient-level performance. Thousands of studies, as well as consensus reports from the National Academy of Medicine and others, have long established a high prevalence of inequity in health care quality.^{ix}

Plan fiduciaries can and should ask their network service providers what methods they use to select and evaluate their providers as well as how often they evaluate them for quality including equity. They should consult experts and analyze for themselves whether these measures of quality are appropriate for their plan, what measures are in place to evaluate providers to ensure they meet quality standards, and how often quality is measured. Most importantly, plan fiduciaries must do their own research and utilize independent resources that currently exist to not only evaluate quality but assist their employees and plan participants in accessing quality information as well, so that they can be informed consumers.

Forward-thinking health plan fiduciaries are already working with their service providers that have expertise in this area on developing methods of providing quality care and outcome information in a format that can be understood easily by interested participants. The more digestible and user-friendly

the information surrounding care quality and outcomes is presented to plan participants, the more likely plan participants are to utilize the information to make well-informed decisions. Even as specific regulations pertaining to the CAA remain in the future, or are unclear or untested, making the effort to proactively inform plan participants of quality and cost choices will go a long way toward demonstrating meaningful commitment to the fiduciary standard. This means doing more than just cutting and pasting links to websites that contain such material, and there are several disruptive tech companies in this area with the goal of providing easy-to-use calculators, comparison algorithms, and smartphone apps to make accessing information relating to the quality of health care at least as accessible for people as accessing information regarding the quality of restaurants in the same area. Figuring out which metrics are material to the quality analysis is a constantly evolving area, but independent expertise exists to help make this determination.

On the upside, in the absence of regulations in place specifying the provision and materiality of quality data to health plan participants, fiduciaries that make a good faith effort to provide what they believe to be the best information available to help participants understand their choices when it comes to quality, outcomes, and other important metrics will already be far ahead of their peers in this area. Additionally, the old adage that “you can lead a horse to water, but you cannot make it drink” is apt; while disclosing quality data to plan participants is a sound move for prudent fiduciaries, it is unclear what the benefits of such disclosure will be, e.g., whether that will lead plan participants to make decisions on providers and facilities based on that data. Like every other part of being an ERISA fiduciary, ***it is more important to establish and put in place a prudent process*** for evaluating and providing material information relating to quality of care to plan participants; whether it is ultimately effective does not impact the fiduciary obligation to act. Putting a sound process in place for identifying and disclosing material quality of care information in a user-friendly manner is another area where ERISA fiduciaries can minimize future risks of litigation and DOL enforcement.

RESOURCES FOR EVALUATING AND EDUCATING PLAN PARTICIPANTS ON QUALITY

As DOL noted in the preamble to the Transparency in Coverage rule, there is substantial quality data available from both government and private sources. This paper is not meant as a comprehensive guide to those resources, but a brief overview for fiduciaries taking needed action.

For background on measuring and reporting quality, a good starting point is The National Quality Forum (NQF), a private standard-setting organization that evaluates and endorses standardized performance measurements that it makes available on its website.^x While NQF does not report the performance of providers, it is the standard-setting body for which measures are endorsed for use in public reporting. To aid those looking to measure the performance of their health plan, NQF provides a printable version of a primer on measuring health care performance titled “The ABCs of Measurement.”^{xi} Because the endorsement process is comprehensive of science, testing, and broad stakeholder consensus, it is advisable for employers to look for NQF-endorsed measures of performance when selecting a quality reporting strategy.

A good start for health plan fiduciaries is The Leapfrog Group (Leapfrog), an organization that was founded over 20 years ago by employers whose vision anticipated the fiduciary standards set forth in the CAA. A national nonprofit founded by the Business Roundtable for the express purpose of independently assessing the quality and safety of health care providers, Leapfrog is one of the nation's most powerful advocates of health care transparency which has led to far more resources for public reporting than existed at its founding. In addition to public policy advocacy, Leapfrog acts on behalf of purchasers to collect voluntarily provided data from hospitals and ambulatory surgery centers, which it publishes to inform value-based purchasing and improved public decision-making.^{xii} Leapfrog brings together experts in clinical quality and measurement to ensure public access to high-integrity data that is most relevant and consequential for plan participants.

Leapfrog delivers provider comparisons that plan sponsors can easily access in a variety of ways, either directly as a free link or through vendors and others described below that aggregate quality data and make it accessible to consumers. Leapfrog data comes from (1) the Leapfrog Surveys, which collect data voluntarily from hospitals and ambulatory surgery centers on safety, quality, and resource use, and (2) the Leapfrog Hospital Safety Grade, a consumer-oriented letter grade system evaluating nearly 3,000 hospitals on how well they keep patients safe from medical errors, infections, and injuries. Leapfrog also provides plans and purchasers with a Value-Based Purchasing Program, a pay-for-performance program aimed at aligning payment to outcomes.^{xiii}

Leapfrog and other employer-driven nonprofits were leading advocates for CMS to publicly report the performance of providers. Today CMS offers a rich set of search tools and public databases on the quality of outcomes at health care facilities to calculate quality for many hospitals, long-term care facilities, rehab facilities, ambulatory surgery centers, and other settings. The largest set of data from CMS is CMS's Hospital Inpatient Quality Reporting Program, under which CMS collects quality data from certain hospitals with the goal of driving quality improvement through measurement and transparency. The metrics reviewed by CMS include mortality, safety of care, readmissions, patient experience, effectiveness and timeliness of care, as well as the efficient use of medical imaging. The data collected through the program is available to consumers and providers on the Care Compare website.^{xiv} What Leapfrog and CMS have in common is a commitment to revealing all levels of performance, from excellent to poor, which is important information for plan participants to avoid problem facilities. Most other sources of public data exclusively report on the highest achievers.

Accreditation status is a key quality credential to report to plan participants. Accreditors increasingly report quality data beyond the achievement of accreditation, but only for those facilities that earned accreditation. The Joint Commission (TJC) is an organization that accredits hospitals, nursing homes, and other facilities and develops and applies standards that focus on patient safety and quality of care. Accreditation from TJC requires on-site evaluation, which assesses compliance with its standards and verifies improvement activity. Health care organizations that receive accreditation or certification from TJC are awarded the patented *Gold Seal of Approval*. TJC provides a searchable website, qualitycheck.org, containing health care organizations that have earned the *Gold Seal of Approval* by TJC.^{xv}

The National Committee for Quality Assurance (NCQA) accredits health plans as well as medical providers and practices. NCQA evaluates 90 measures across six “domains of care,” including the effectiveness of care, access/availability of care, and experience of care.^{xvi} According to its website, the NCQA Health Plan Accreditation program builds upon more than 25 years of experience to provide a current, rigorous, and comprehensive framework for essential quality improvement and measurement, including both clinical performance through HEDIS and consumer experience through CAHPS.^{xvii} Prudent fiduciaries can use the NCQA standards to evaluate and report on health plans and medical practices that achieve NCQA accreditation, examining metrics including:

- quality management and improvement
- population health management
- network management
- utilization management
- credentialing and recredentialing
- members’ rights and responsibilities
- member connections
- Medicaid benefits and services

NCQA offers many additional programs geared at raising the quality of health plans, including health equity accreditation programs, an emerging focus in health care closely related to quality of care. Improving health equity across all populations requires a commitment to eliminating health disparities in underserved populations; doing so results in better health outcomes across the board while reducing overall treatment costs. Integrating information related to health equity into the process of providing material information related to quality of care is a great way to limit plan fiduciaries’ future exposure to enforcement action and litigation.

Plans can report on quality, including health equity data, by directing participants to user-friendly websites that provide such information. The Leapfrog Hospital Safety Grade site is a good example of quality data that fiduciaries can utilize and provide to plan participants immediately at no charge and is presented in a format that users can easily understand and interact with.^{xviii}

The CMS searchable website allows anyone to compare providers, hospitals, nursing homes, home health care, hospice care, inpatient rehabilitation facilities, dialysis facilities, and long-term care facilities. This provides quite a bit of data for almost every possible health care need, and it is used by other vendors as well as incorporating it into public-facing sites. Additionally, the Office of Personnel Management (OPM), the public agency that administers federal employee benefits, provides a searchable site where anyone can enter their zip code and compare health care quality and customer experience scores for plans in the same area. This is particularly useful for employees choosing among more than one health plan as it gives all types of quality data from the customer experience perspective in addition to the quality of care.^{xix}

All of these sources of quality data are limited in scope, and there is a need for a wider range of ratings on more nuanced issues, like the quality of individual hospital units or the outcome record of individual surgeons or other clinicians. A number of additional vendors and popular rating websites are innovating to improve the breadth of data available to plan sponsors to integrate into their benefit design, usually for a fee. Most build from other data, which may include data from Leapfrog, CMS, The Joint Commission, and NCQA. These vendors include Castlight, Embold Health, WebMD, and others that offer tools for searching out quality data including by physician as well as by hospital or facility. Some vendors offer direct access for consumers as well, such as Healthgrades, Vitals, and ZocDoc. These sites offer information designed to reflect what consumers use for their own assessment of quality, ranging from the percentage of patients who suggest a health care provider to the wait time once in the office, parking accessibility, and many issues in between, including quality and patient reviews, type of insurance accepted, distance, and the doctor's gender. Some of these sites also provide data showing how long health professionals have been in practice, as well as their education and training, licensure and certification, hospital affiliations, and languages spoken.^{xx}

STRATEGIES FOR MAKING QUALITY HEALTH CARE FOUNDATIONAL TO A BENEFITS PROGRAM

Ensuring that plan participants have access to independent comparative quality data to help them make decisions about where to seek care is the first step for providers of group health plan coverage. It is important that health plan fiduciaries begin discussing quality and performance data and how to provide the most helpful data in a format usable by plan participants. Many vendors, advocates, and government agencies such as those described above will offer innovative tools for effective communication.

In addition to accessing and sharing quality of care information, there are other measures health plan fiduciaries can investigate and consider as methods of facilitating participant access to the best quality of care and to determine whether the quality of their health plans could be improved. Plan design strategies in health care can be a game changer, producing better outcomes with quality as the cornerstone, and further aligning with the principles of good fiduciary stewardship. Some of these measures include:

- **Switching to a narrow, high-performance provider network, or keeping a broader network but incentivizing employees to choose higher quality providers.**

There are ways to keep a broad network while incentivizing employees to choose higher-quality providers. Some of these include implementing (a) centers for excellence programs for some medical procedures such as knee replacement surgery; (b) a tiered network system where employees are financially incentivized to go to high-quality providers and disincentivized to go to low-quality providers; (c) alternative payment models (APMs) that shift financial risk to providers and reward quality; and (d) value-based plan design models that lower cost-sharing for high-value services.

➤ **Use advanced value-based payment strategies.**

In addition to network selection, there are a number of new models of agreements focused on payment and contracting terms with selected providers that allow plan sponsors to properly reflect quality and cost-effectiveness in payment terms. These include bundled payments, value-based bonuses or penalties, capitation, and tiered payment levels. Such contracting innovations are not robust for many TPAs and health plans, but some plan sponsors unable to find a TPA to contract adequately for value have implemented direct contracts with providers for select services, which shows that plans can implement value-based contracts on their own, in some cases eliminating the need for a TPA. Excellent resources for plan sponsors are available from [Catalyst for Payment Reform](#)^{xxi}.

➤ **Care coordination.**

While the new transparency tools available as the result of the Hospital Price Transparency Final Rule, Transparency in Coverage Final Rule, CAA, and NSA will provide anyone who wants access to cost information, employees tend not to shop for health care even when they have access to price shopping tools. Many employees simply don't have the time or education to study quality or price before getting care, and our health care system is particularly confusing, not lending itself to easy investigation. Though it has been changing rapidly, the reality today is that many plan participants go to whichever hospital is close by or wherever their doctor sends them. A strong navigation system combined with a coordination of care system would help encourage patients to favor high-quality providers. For some medical conditions, such as diabetes or substance use disorders, a care coordinator could save plans and participants substantial sums of money and greatly improve the participants' quality of care.

➤ **Reevaluate the value of your high deductible health plan.**

Plan sponsors and fiduciaries should evaluate whether levels of deductibles and copays provide the best value or if they might be undermining the goal of increasing quality. Plans can give employees access to the best providers and a great quality health care plan, but if the participants cannot afford to pay the deductible required to go to the doctor, then the plan is not achieving its goals. When plan participants forego or delay routine healthcare management, it often leads to higher cost care.^{xxii}

One of the stated purposes of high deductible health plans when first permitted by Congress was to facilitate consumer "shopping" for health care services as a means of creating a market for high-value care. At the same time, Congress established Health Savings Accounts, triple-tax-protected accounts that may be created to accompany a high-deductible health plan that employers have the option to subsidize. A subsidized high-deductible health plan supports the incentive to "shop" without eroding access to plan participants unable to afford the deductible. No matter how plan fiduciaries structure deductibles, copays, and subsidies, the CAA clarifies the obligations fiduciaries have to ensure transparency for participants in an effort to facilitate informed decision-making, including both cost and quality of care. That obligation for transparency is accentuated with high deductible plans, which require more informed decision-making by plan participants to achieve value.

➤ **Health Equity.**

In reviewing their health care plans, sponsors and fiduciaries should also consider their health plan's population. Utilizing existing data can help fiduciaries tailor a program to the particular needs and health risks of the plan's employee population and inform plan participants of treatments and providers that are most likely to provide equitable care. For example, telehealth may be an option that allows workers in rural areas to obtain better quality health care than what is available where they live and give them access to a network of specialists they might not otherwise have. Black women are three times more likely to die from childbirth than other women, so informing Black plan participants of key issues to consider in selecting a hospital for delivery demonstrates strong fiduciary leadership; conversely, failure to inform the same plan participants of these key issues could potentially increase the litigation risk to the employer, depending on the facts and circumstances.

CONCLUSION: A HISTORIC MOMENT

ERISA and the CAA amendments pivot on the adage that a journey of a thousand miles begins with a single step. The process plan sponsors use to aim for the right outcomes is the first critical step--not the outcomes themselves, which come later. Employers must engage in a documented process to show that they are acting in the best interest of their employees. ERISA does not require perfection, but it does require a meaningful analysis of quality as well as costs.

A marketplace of tools and resources exists for plan sponsors to utilize in their efforts to support employee decision-making and to promote the quality and value of care. Utilizing these tools demonstrates loyalty to the interests of their employees. Not only will employers be able to improve outcomes and reduce costs to themselves and their employees, but they will have major bona fides to recruit and retain a healthy, high-quality workforce. High-quality health care is in everyone's best interests, and with the passage of the CAA, employers have a unique opportunity – and responsibility – to make a tangible difference in the health of our country.

AUTHORS

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Jamie Greenleaf is the Co-Founder of Fiduciary In A Box. She has spent her entire career acting in a Fiduciary capacity, helping employers design and implement retirement programs to create better outcomes for employees. In 2019, Jamie founded TILT, a health plan technology and consulting firm, to help employers fulfill their Fiduciary obligations by controlling cost and providing better health benefits. She recently turned her knowledge of the Fiduciary process into Fiduciary In A Box (FIAB). FIAB is a patent-pending platform that guides an employer through Establishing, Documenting and Maintaining a fiduciary process for the management of their health benefits plan. Jamie is a Specialty Leader (Health Care Plan specialization) with the Center for Board Certified Fiduciaries™ (CBCF), a group of fiduciary experts selected for their skills, best practices, and knowledge.

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FOOTNOTES

ⁱ <https://www.kff.org/other/state-indicator/total-population/>?

ⁱⁱ 29 U.S.C. § 1104(a)(1)(A) and (B)

ⁱⁱⁱ 29 U.S.C. § 1106(a)(1)(C); 29 U.S.C. § 1108(b)(2).

^{iv} 29 C.F.R. § 2250.404a-5.

^v DOL Information Letter 02-19-1998.

^{vi} *Id.*

^{vii} www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/understanding-your-fiduciary-responsibilities-under-a-group-health-plan.pdf.

^{viii} Transparency in Coverage, 85 Fed. Reg. 72213 (Nov. 12, 2020).

^{ix} <https://nam.edu/an-equity-agenda-for-the-field-of-health-care-quality-improvement/>

^x <https://www.qualityforum.org/Home.aspx>

^{xi} www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=44311

^{xii} <https://www.leapfroggroup.org/>

^{xiii} <https://www.leapfroggroup.org/ratings-reports>

^{xiv} See CMS Hospital inpatient Quality Reporting Program web page at <https://www.medicare.gov/care-compare/?providerType=Hospital&redirect=true>.

^{xv} <https://www.qualitycheck.org/>

^{xvi} <https://www.jointcommission.org/>

^{xvii} <https://www.ncqa.org/programs/health-plans/health-plan-accreditation-hpa/>

^{xviii} <https://www.hospitalsafetygrade.org/>

^{xix} <https://www.opm.gov/healthcare-insurance/healthcare/plan-information/compare-plans/quality>

^{xx} <https://www.healthgrades.com/>

^{xxi} <https://www.catalyze.org/>

^{xxii} <https://www.fiercehealthcare.com/payer/study-high-deductible-health-plans-aren-t-making-members-better-healthcare-consumers>.