Health Plan Comparison Tools in Exchanges: Helping Consumers and Employers Make the Best Choices

Paper Prepared by Consumers' CHECKBOOK/Center for the Study of Services

Executive Summary

Health Insurance Exchanges have the potential to help millions of Americans get affordable health insurance coverage and access to high-quality care, and can contribute to overall improvement in the quality and efficiency of the health care system. To reach that result, Exchanges will have to be effective in various challenging functions. A key one of these functions is giving consumers and employers a health plan comparison tool to assist them in selecting the plans that best meet their needs and preferences.

This paper recommends best-practice features to be built into any such comparison tool. These recommendations are based on the extensive experience of the nonprofit Consumers' CHECKBOOK/Center for the Study of Services (CHECKBOOK/CSS) organization in providing consumer information and ratings of the quality and prices of a wide range of types of service providers. Particularly important for these recommendations is CHECKBOOK/CSS's research, testing, evaluation, and experience for the past 32 years as it has implemented and refined a health plan comparison tool for the eight million consumers who get insurance through the Federal Employees Health Benefits Program (FEHBP).

CHECKBOOK/CSS also has made available a brief summary of its recommendations and a demonstration of the tool it has created with most of these best-practice features at www.checkbook.org/plancompare.

Among the many tool features elaborated more fully in this paper, CHECKBOOK/CSS recommends that all Exchanges have a tool that lets users see—

- ***The true insurance value of each plan***—how plans compare on total cost (premiums plus out-of-pocket costs) based on average health care expenses of populations of similar age and family composition, taking into account any tax and subsidy effects.
- ***Possible expenses in each plan in very good years and very bad years*** (including years when the user's expenses exceed out-of-pocket limits) and the likelihood of having such years.
- ***Likely effects on out-of-pocket costs of any known future expenses***—for example, an expensive operation or a pregnancy.
- ***An Exchange-wide provider directory*** so consumers can easily see which plan networks include their doctors, and can see quality measures for each available doctor and hospital.
- ***How plans compare on care and service quality***—plan ratings by members, frequency of member complaints, quality and breadth of provider network, plan-provided health improvement programs, accreditation, etc.—allowing the user to focus on the quality dimensions of greatest personal interest.

- ***Any coverage gaps and any unusual benefit strengths***—and why they matter.
- ***Clear, simple explanations and videos*** that will de-mystify insurance decisions even for unsophisticated users.
- ***Excellent, personalized plan choices in less than five minutes***—while allowing users, if they are able and so inclined, to drill down for extensive detail.

The online version of such a tool must be designed to enable family members, counselors, Navigators, brokers, and other intermediaries to give personalized advice and prepare personalized written materials.

CHECKBOOK/CSS is making its recommendations and its best-practices model tool available to states and others responsible for building Exchanges. CHECKBOOK/CSS also stands ready to provide advice to those building their own tools, and can actually build and/or operate a tool for any Exchange that wishes to have it do so. The mission here is to have user-friendly tools broadly available to help consumers and employers get the best possible value for their money in health insurance and health care.

The Research, Testing, Evaluation, and Experience Behind The Recommendations in This Paper

Many ideas are being put forth on the design of Exchanges and how Exchanges can help users choose plans. CHECKBOOK/CSS has brought to this subject actual research, testing, and experience serving *hundreds of thousands* of consumers who, over the past 32 years have used *CHECKBOOK's Guide to Health Plans for Federal Employees* (*Guide*). The *Guide* for Federal employees compares health plans available to the eight million employees and retirees in the largest existing health insurance "exchange" in the U.S., the Federal Employees Health Benefits Program (FEHBP). The FEHBP has been one of the models for the Exchange concept; it currently includes more than 200 health plans, with about 20 available throughout the U.S. and the other plans available in specific states or regions.

For many years, this *Guide* supported itself entirely by being purchased by individual employees and retirees—good discipline to foster development of a tool that is useful and consumer-friendly. (None of CHECKBOOK/CSS's publications or websites carries any advertising.) Over the past decade, dozens of Federal departments and agencies (HHS, Labor, IRS, Federal Reserve, U.S. Senate, and many others) have paid for online access to the *Guide* to help their employees make the best plan choices.

Providing this tool comparing plans has offered an invaluable opportunity to learn what is needed in such a tool and to learn how best to address the practical issues of tool feasibility, cost, and implementation. CHECKBOOK/CSS has observed usage patterns, surveyed users, and answered insurance questions in Q&A forums. And its experts have made a practice of actually meeting personally each year with individuals and small groups to provide personal advice and continually learn about consumers' goals in selecting insurance plans and the indicators and reasoning consumers rightly or wrongly believe will lead them toward the right plan.

This paper also draws on what CHECKBOOK/CSS has learned about the validity, feasibility, and cost of various methods for evaluating and reporting on the quality and cost of health care and insurance services through its various other activities. These activities include producing *Consumers' CHECKBOOK* magazine and www.checkbook.org (which are supported by consumers and carry no advertising) with evaluations of various types of service providers, including doctors, dentists, hospitals, and auto and homeowners insurers; administering CAHPS surveys of health plan members (more such surveys than any other organization, and including in recent years managing, under contract with CMS, all of CMS's surveys of members of Medicare Advantage and Prescription Drug plans); administering the nation's largest surveys of patients about doctors using the Clinician/Group CAHPS surveys, both under its own sponsorship and under contract with such groups as Massachusetts Health Quality Partners and the Pacific Business Group on Health; and serving on national measure-development committees such as (for its initial years) NCQA's Committee on Performance Measurement, responsible for selecting HEDIS measures of clinical quality in health plans.

Reaction of Consumers and Others

CHECKBOOK/CSS has described the features set out in this paper and shown its demonstration model health plan comparison tool to many consumer, business, and policy leaders. These leaders have expressed enthusiastic support for the features as described and for the model tool as demonstrated. For example, it is expected that the comment letter submitted by the Consumer-Purchaser Disclosure Project on the first set of proposed regulations for the Exchanges, and signed by a large number of leading consumer and purchaser organizations, will call for every Exchange to implement a comparison tool with the range of features recommended in this paper, which features have been described and demonstrated in recent months to many of those signer organizations.

CHECKBOOK/CSS has also described the comparison tool features and demonstrated the recommended best-practices model tool to government leaders responsible for implementing Exchanges in a number of states, and these leaders have been enthusiastic about what has been described and demonstrated.

Moving Forward

To advance the mission of having the kind of tool described in this paper implemented in most or all Exchanges, CHECKBOOK/CSS is sharing its description of features and its demonstration model broadly. CHECKBOOK/CSS is also prepared to advise Exchanges as they put tools in place; to implement and integrate the recommended model within any exchange that wants that help; to implement such a model as an outside resource linked to any Exchange, passing data back and forth with the eligibility, enrollment, and other functions of the Exchange; or to set up such a model alongside any Exchange for use by Navigators, brokers, and others that are helping consumers or employers make insurance choices.

CHECKBOOK/CSS intends to continue to enhance its best-practices model tool and expand the available knowledge base for anyone implementing a tool. CHECKBOOK/CSS is doing user-testing of various tool design options on an ongoing basis. It will continue to test and refine tool options in different environments with different types of users. It will describe fully the model tool's underlying logic to the extent necessary to make it easier for other organizations to adapt and adopt, and will provide specifications of the data and other inputs that can make adoption and implementation by other organizations as easy as possible.

The goal is to have the best possible health plan comparison tool broadly available to consumers and other users.

The Health-Plan Comparison Tool

The best-practices health plan comparison tool model CHECKBOOK/CSS is recommending for Exchanges draws heavily on the tool the organization continues to offer and improve in its *Guide* for Federal employees, but the tool model recommended for Exchanges is designed to take into account various special considerations. These considerations include the range of different types of consumers who can be expected to participate in the Exchanges; the tax

subsidies and out-of-pocket limits in the Exchanges; data sources that will be available in the Exchanges; the interface with the eligibility, enrollment, and other functions of the Exchanges; the interface with Medicaid and other sources of insurance protection; and many other considerations in this new environment.

A key requirement of an effective tool is that the user be able to get to an excellent plan choice quickly, ideally in less than five minutes. The tool must be able quickly to rank plans on cost; show the availability of the user's preferred doctors, if any; and provide an overall indication of plan quality. Users who are able and so inclined must be able to drill down, filter, and sort to get more details. But CHECKBOOK/CSS's research has revealed that, unless an excellent answer is available quickly, many consumers will drop out and make decisions based only on inadequate criteria like the size of the deductible or premium, often wasting large amounts of money and getting inferior coverage and care quality.

The recommended tool features listed below will get users to an excellent answer quickly and provide much more information and help for users who want more.

Information on cost

- Providing an estimated average yearly cost (premium plus out-of-pocket cost) for each plan for the user on an *insurance value/actuarial* basis, based on the user's age, family size, and possibly other characteristics like self-reported health status—thus quickly answering the highest priority question for most users (which plans will cost least) in a valid and easily understood way;
- Showing the range of uncertainty (how the user's expenses would compare among plans in a very good year or a very bad year)—and showing the likelihood of having these more extreme experiences;
- Showing the maximum out-of-pocket cost for the user for each plan;
- Enabling the user to feed into the calculation information on known future usage (for example, a pregnancy or planned hospitalization);
- For a selection of disease scenarios, illustrating the expense effects of different plans' benefit structure differences—if possible, drawing on coverage examples plans will be required to provide under the Patient Protection and Affordable Care Act (ACA) regulations;
- Allowing the user to take into account various tax and premium subsidies and the possible effects of health savings accounts and flexible spending accounts, if available—with appropriate calculators to let users see the effects of different assumptions;
- Describing benefit provisions in plain, user-tested language with illustrations of how these provisions would work for an actual policyholder—taking advantage of the ACA-required Summary of Benefits and Coverage information;
- Highlighting benefit gaps that might surprise users (for example, non-obvious exclusions from out-of-pocket cost limits) and any especially generous provisions;
- Enabling the user to understand the possibility that the premium subsidy the user is actually entitled to might change over time and helping the user deal with that possibility;

Provider directories and information on quality

- Providing an Exchange-wide provider directory that lets users give the names of doctors they want to use and automatically see which plans these doctors participate in—without having to access and dig into each plan's separate provider directory;
- Including provider directories with provider-quality information that users who don't already have providers can use to identify good provider choices—including providers who are participating in the most efficient and effective practice models;
- Giving easily understood descriptions and ratings of various aspects of each plan's care and service quality—including summary measures and convenient ways for the user to drill down to what interests the user (by disease, by type of service, etc.);
- Summarizing information on each plan's programs to foster healthy living, care coordination, case management, shared decision-making, patient safety, and other ways to promote health and wellness—thus helping users to compare plans on these quality dimensions and giving plans incentives to strengthen these programs;

Other features

- Describing, and assessing the actual value of, special plan benefits (for example, coverage or discounts for vision care, hearing aids, gym memberships, or alternative therapies);
- Enabling users easily to focus on aspects of plans of most interest to them (but not encouraging early filtering that may cause the user to miss differences that would be considered important by the user if known);
- Providing easy mechanisms for family members, Navigators, brokers, and other intermediaries to use to help consumers, including by printing and distributing helpful hard-copy comparisons and summaries for persons for whom electronic access to the information will not be suitable, and by highlighting interesting choices for the mass media;
- Including audio and video explanations of terms and concepts that might be confusing;
- Including extensive consumer advice, similar to what is included in CHECKBOOK/CSS's current *Guide* for Federal employees, to fit the facts and choices consumers will have in the different Exchanges—and making this advice easily accessible in response to specific user questions or requests for help;
- Including ongoing programs to publicize and promote the availability and ease of use of the plan comparison tool to make the very idea of searching for a health plan appealing to the public, rather than intimidating and unpleasant;
- On an on-going basis, observing and testing the usability of the website and tool features, observing usage patterns, responding to user questions about the website and about plan-choice decision considerations, and adapting the website and other tool features to make them more helpful.

Depending on the specific circumstances, policies, and data availability in a state, other possible comparison tool features are—

- Integrating information on other plans that Exchange users might at times be eligible for—for example, information on Medicaid plans' provider lists so that users can see how likely it is that they can keep the same doctors if they have to move from any specific private plan to a specific Medicaid plan or back;

- Making some features and information in the Exchange's comparison tool available outside the Exchange as a general insurance/health care resource;
- Estimating the potential cost impact of differences in plans' drug formularies and drug cost-sharing provisions—and exploring the possibility of introducing some features similar to the Medicare Prescription Drug Plan drug coverage comparison tool;
- Illustrating for users the potential cost impact of differences in plans' network breadth, plans' allowable cost levels in and out of network, and different providers' fee levels.

Below, some of these features and some of the related issues are described more fully.

Insurance Value of Each Plan Versus Other Cost Comparison Approaches

CHECKBOOK/CSS's surveys and observation of use patterns have shown that health plan comparison tool users are most interested in comparing the total costs they can expect with different plans. Several different approaches have been used in tools intended to help consumers compare plan costs. These alternative approaches are described here, along with a description of what CHECKBOOK/CSS's recommended best-practices model does—very different from other approaches but incorporating the useful elements of each approach.

Benefit and coverage comparisons
Unfortunately, the cost comparisons in most plan comparison tools go no further than giving descriptions of each plan's coverage provisions, including deductibles, co-payments, coinsurance, and out-of-pocket limits. This is currently true of the Massachusetts Connector, HealthCare.gov, the Utah Health Exchange, Maryland's Virtual Compare website, and many others.

Normal consumers just cannot assess the dollar consequences of the coverage differences. Yet, to find good value, it is essential for the user to know how these different coverage provisions can be expected to impact actual out-of-pocket costs. *Is a $200 deductible with a $10,000 out-of-pocket limit better for my family than a $1,000 deductible and a $4,000 out-of-pocket limit?* What about differences in coinsurance percentages, in whether the deductible does or does not count toward the out-of-pocket limit, etc.?

The model CHECKBOOK/CSS recommends has the coverage descriptions—taking advantage of, among other inputs, the information from the Summary of Benefits and Coverage for each plan as specified under the final ACA regulations. But even the best such descriptions are much less than what consumers actually need. The best practices for Exchanges must go further.

Known usage model
Another approach, which might be referred to as the "known-usage" model, is to have the user input all or most of the health care system uses the user expects to have in the coming year (how many of which drugs, how many doctor visits, etc.)—and then have the comparison tool estimate a typical provider charge for each of these uses and calculate how much the user would have to spend out of pocket under each plan as the member's share of those expenses. That approach has some intuitive appeal, and is the common approach for deciding how much

to put into a flexible spending account, but it falls far short of being sufficient for selecting *insurance* plans.

The fundamental problem with such a known-usage approach is that a key reason for *insurance* is to protect the policyholder against the cost of what the policyholder can't predict—a serious accident, new disease, or new treatment plan. With the known-usage approach, the out-of-pocket cost estimates don't reflect those unexpected costs—though reflecting them might dramatically affect the relative ranking of plans.

The type of tool CHECKBOOK/CSS recommends—and its demonstration model—will allow users to adjust cost calculations to take into account large known up-coming expenses. And the best-practices tool will certainly take into account known factors that contribute to risk—age, family size, and possibly factors like self-reported health status. But a key distinguishing feature of the tool CHECKBOOK/CSS recommends is that it will take into account costs—possibly very large costs—that *cannot* be anticipated.

The insurance value model

The best-practices tool CHECKBOOK/CSS recommends does this by featuring an "insurance value" approach. It estimates average expected costs for the user in the coming year (premium plus out-of-pocket costs) based on extensive data on the distribution of individual and family expenses of persons similar to the user (similar age, family size, etc.) assuming nothing specific is known about future usage. For this estimate, the recommended model uses (as CHECKBOOK/CSS has for many years in its *Guide* for Federal employees) data from the Federal government's Medical Expenditure Panel Survey (MEPS), which shows the distribution of expenses for a sample of Americans. And the recommended best-practices model can also take into account other data that are becoming available from other sources, including state All-Payer Databases.

CHECKBOOK/CSS has routinely used data of this kind in the analysis that is the basis for its current *Guide* for Federal employees, and the organization is continually re-examining the data and refining the recommended model. (CMS's comparison tool for Medicare Advantage plans, using data from the Medicare Current Beneficiary Survey (MCBS), has elements of the approach CHECKBOOK/CSS has always used in its *Guide*, but unfortunately appears to be the only other tool that takes this insurance-value approach.)

Based on using millions of patient expenditure records, this recommended best-practices model can construct samples of usage/expense distributions of individuals and families for each of various age/family size/health status/geographic and other characteristic combinations. It can take into account the probability of each of various levels of total expense and each of various breakdowns of these total expenses among different types of providers and services. Then, using these expense amounts and probabilities, it can calculate for each health plan's benefit structure a best estimate of likely out-of-pocket costs for a user of given age, family size, and other characteristics. Plans can then easily be compared based on total costs.

Why the Insurance Value Needs to Be Determined

Some might wonder why it will be important to have a plan comparison tool determine the insurance value of each plan. Since ACA requires that there be "metal" levels of plans—bronze, silver, gold, and platinum (and catastrophic)—and that each plan within a level have the same actuarial value, isn't premium all that matters?

In fact, different plans with the same actuarial value might have very different value to a consumer with specific characteristics. Under ACA, the actuarial value may be determined based on the percent of expenses the plan would pay and not pay for a broad population representative of the *total* population, including 25 year-olds, 40 year-olds, and 55 year-olds with different family sizes and other characteristics. Among two plans that have the same value for such a broad group, one might offer much better protection, and therefore better insurance value, for a subgroup—for example, for persons 55 years old with relatively poor health status. If plans at each "metal" level have very similar coverage provisions (co-payment levels, for example), as might be the case depending on what flexibility a specific Exchange's rules allow, there will be less likelihood of big differences in relative insurance value, or expected out-of-pocket costs, for different plans at a given metal level for different population segments. But there are likely still to be substantial differences in relative insurance value to a user who, quite reasonably, wants to compare plans across levels—a bronze plan to a gold plan, for example.

To illustrate, CHECKBOOK/CSS's analysis of plans in the Massachusetts Connector reveals that, for a given consumer, it is not uncommon for a Silver-level plan that has a premium $1,000 *higher* than the premium in a Bronze-level plan actually to have a total expected cost (premium plus out-of-pocket cost) $1,000 *lower* than the Bronze plan.

The Range of Risk

For each plan, the estimated average likely cost (premium plus out-of-pocket) for each user's combination of age, family size, and other characteristics will be the correct focus for many or most users. But users might reasonably want to know how plans would compare in a really bad year or a really good year—and how likely such years are to occur. The type of tool recommended here will enable users to see how plans would compare for a population with the user's age, family, and other characteristics that ends up being in, say, the top 10 percent for expenses (and also for a similar population that ends up having no expenses or being in, say, the lowest 10 percent). This analysis is done based on the same individual expense level data (from MEPS and other sources) used for the analysis of average likely cost.

An important part of this type of comparison is to show the user's maximum possible cost for each plan. Showing that figure is less straightforward than it might seem. Even in systems (for example, the Massachusetts Connector) where basic benefit descriptions state a single out-of-

pocket limit to the policyholder, there are often fine-print exceptions—for example, where the limit is different for drugs than for other types of expenses. It is to be hoped that, when the Summary of Benefits and Coverage regulations under ACA are finalized, there will be no significant loopholes or ambiguities in the benefit descriptions. CHECKBOOK/CSS has submitted comments on the proposed regulations.

Letting Known Future Expenses, or Likely Expenses, Be Reflected in the Comparisons

While it would be unwise to have a comparison tool built solely on calculating out-of-pocket costs based on *known* or *planned* usage, it does make sense to *include* in the out-of-pocket cost calculations large future expenses that can be reasonably well anticipated. The best-practices tool CHECKBOOK/CSS recommends will allow users to include such known expenses.

An example would be something like a pregnancy, which is planned, or a condition diagnosed before plan-choice open season if that condition is known to require large future expenses. To enable users to reflect expenses for such conditions in the plan comparisons, it is desirable for a tool to give the user a general estimate of the level and distribution of expenses for a variety of types of high-cost conditions/treatments. Then the tool can include a portion of these known expenses for the user's high-cost condition/treatment in addition to the expense estimates already included in the insurance-value model for users of the same age, family size, etc.

Illustrative Disease Scenarios

To provide context for users, it will be useful to let users go to a feature that compares plans with regard to out-of-pocket costs for selected disease scenarios. These can include at least the maternity, heart attack, and diabetes examples plans are required to document by the proposed ACA regulations. These scenarios will have educational value, showing users how significant the differences among seemingly similar plans can be in the event of serious health care needs.

Plan Quality

A best-practices plan comparison tool should, within the limits of available resources, include extensive information on plan quality. It should include an overall *quality* rating, for quick reference alongside overall *cost* comparison information, based on a formula that takes into account various dimensions of quality.

To the extent feasible, the tool should give the user the ability to drill down for, and sort on, information on various aspects of quality that are of most interest to the user—measures related to a specific health care circumstance such as having young children or having diabetes, for example, or measures of specific aspects of care or service quality like quick access to doctors or trouble-free claims handling.

Subject to the need to avoid making use of the tool too burdensome and time-consuming for users, the user can be given the opportunity to give weights to the different quality dimensions as a basis for the tool's calculation of a user-specific overall quality rating.

CHECKBOOK/CSS has found from surveys of users of its *Guide* and from monitoring of patterns of use, that measures of plan quality are not of as great interest to such users as cost measures and information on which plans have the user's preferred doctors among their participating providers.

But there are compelling reasons to strive to enhance user interest in quality measures. Quality differences among existing plans in some cases would be important to users if the users understood them. And an Exchange that provides a marketplace of informed consumers may have the potential to be an important force for overall improvement in the quality and efficiency of the health care *system*—driving plans and providers to redesign practices in ways that, for example, produce better outcomes, safer care, and reduced costs.

In its *Guide* for Federal employees, CHECKBOOK/CSS continues to experiment with different ways to guide consumers into and through information on plan quality, and to observe how this information is used. And CHECKBOOK/CSS wants to work with others implementing plan comparison tools to design those tools to engage consumers and other users in the most effective ways.

The specific quality measures that will be used in any given Exchange will depend on the data available on plans in that Exchange. In CHECKBOOK/CSS's *Guide* for Federal employees and retirees, quality measures include—

- Results of CAHPS member experience surveys;
- Accreditation status;
- Performance on HEDIS measures of the extent to which members get the tests and treatments they should and how members stack up on a few intermediate outcomes;
- Information on frequency of disputed claims, including specifically claims disputes ruled against the plan; and
- Among the community's doctors who are high-rated on selected quality measures, the percentage who participate in the plan—taking into account the total size of the plan's network.

In its *Guide* for Federal employees, CHECKBOOK/CSS has also experimented with another feature that might be desirable for tool developers in Exchanges to include: write-ups using descriptive information voluntarily provided by each plan on each plan's programs to improve health outcomes through effective case management, programs to prevent hospital readmissions through effective handling of hospital discharges, programs to improve patient safety and reduce medical errors; and programs for wellness and health promotion.

The availability of information on quality of plans will depend on the commitment and legal leverage the Exchange and collaborating government and non-governmental entities have for requiring plans to provide information and ensure the accuracy of the information—and on policy decisions as to how much cost of quality measurement to impose on plans. It will also depend on the resources the Exchange or other entities are prepared to devote to data collection and auditing. And it will depend on the extent to which plans are already reporting on quality

measures because of demands of large employers and other entities independent of the Exchange.

Some quality measures are required to be developed under ACA. In particular, the law requires the Secretary to develop a survey system to evaluate the level of enrollee satisfaction with qualified health plans offered through an Exchange, for each such qualified health plan that had more than 500 enrollees in the previous year. But it is not yet clear how or when this requirement will be implemented. Similarly, the law requires that the Secretary develop reporting requirements for use by a plan or issuer of insurance with respect to plan or coverage benefits and health care provider reimbursement structures that improve health outcomes through implementation of quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives. But it is not yet clear how or when such reporting by plans will take place or how the accuracy of such reports will be ensured. And qualified plans will have to be accredited—but, again, the effective date of that requirement is not yet clear.

Getting good data on plan quality for use in a plan comparison tool will require resourcefulness on the part of the entity implementing such a tool--especially in the period before all ACA quality reporting requirements are fully implemented. Anyone implementing a tool should look first for existing data sources that can be used or adapted. For example, it will be important to—

- Determine which issuers of insurance with plans that will be participating in the Exchange already have relevant plan accreditation through NCQA or another accrediting organization and which already have CAHPS member experience survey results and/or HEDIS measurement results.
- Determine for which plans in which states there is relevant information about complaints and disputed claims with the state insurance department (CHECKBOOK/CSS's extensive experience using complaint information from state agencies for reports for CHECKBOOK magazine and checkbook.org on auto, homeowners, and health insurers has revealed substantial state-to-state variation).

Any information collected on an issuer through existing processes will, of course, have to be evaluated for relevance/applicability to the issuer's specific qualified plans being offered in the Exchange.

The eValue8 program of the National Business Coalition of Health (NBCH) is a good example of what might be possible to fill in important information on key dimensions of plan quality. NBCH works with purchasers in specific markets to get plans to answer, and document responses to, a wide range of questions about programs the plans have and results the plans achieve related to various dimensions, such as:

- Consumer engagement,
- The functionality of provider choice tools,
- The quality and visibility of tools and other resources to help members make treatment decisions,

- Personal health record availability to members,
- Disease management programs,
- Plan effectiveness in identifying members in need of chronic disease care or support,
- Plan effectiveness in helping coordinate care for patients with multiple chronic conditions,
- The extent to which members who need disease management services are getting such services,
- Plan success in improving patient safety, and
- Plan success in avoiding hospital re-admissions.

Then the NBCH team and the purchasers engage plans in developing and monitoring strategies for strengthening such programs and spreading the use of best practices.

The NBCH approach has been traditionally focused on assisting employers in their role as purchasers. But CHECKBOOK/CSS is in negotiations with NBCH about designing ways for the eValue8 process and various relevant information elements collected in that process to be directed to consumers, both within Exchanges and outside Exchanges. And NBCH is already moving in this direction in some specific arenas, as evidenced by the fact that NBCH was recently awarded a grant from the Robert Wood Johnson Foundation to use eValue8 data to support HHS's Partnership for Patients public-private partnership. Under that grant, NBCH will create a request for information asking health plans what they are doing to reduce hospital-acquired conditions and readmissions. The data reported by health plans will be made available on a public website for use by purchasers *and* consumers, as well as interested federal agencies such as HHS.

The issues the eValue8 process focuses on are not all salient for consumers, as opposed to purchasers. But many of the issues can be expected to be of great interest to consumers. An important attribute of many of the plan performance elements eValue8 examines is that consumers will easily understand that plans can differ on these dimensions and that these are dimensions that are in the direct control of the plans. In contrast, consumers often question whether the dimensions measured by HEDIS measures are attributable to the plan--as opposed to being attributable to specific providers, with results for the member determined by which doctor or other provider the member selects rather than by selection of plan.

A key type of quality information that an Exchange will be able to deliver to consumers quickly even if such information is not already available from plans is results of CAHPS surveys of members. These survey results will show what members say about how easily they can get the care they need, how well doctors in the plan communicate, how often claims are processed quickly and correctly, how they rate their personal doctors and specialists, and other questions, including an overall rating of the plan. Such surveys can be done of members of similar plans sponsored by issuers *pre*-exchange, and can be quickly implemented after members who have enrolled through an Exchange have had an adequate period of experience.

Based on its experience performing such surveys of members of hundreds of plans, CHECKBOOK/CSS estimates that, if multiple plans or issuers are included, an independently sponsored CAHPS survey of 1,000 enrollees per plan or issuer using a standard two-wave mail

survey can be done for about $3,000 per plan or issuer. That might be a manageable price-point for any plan or for an Exchange itself to produce survey results that are known to be of relatively high interest to consumers.

As another interesting, though less-rigorous, way to get member feedback quickly and at low cost, an Exchange's plan comparison tool can collect e-mail contact information from users of the tool and follow up with e-mail surveys to ask users about their experience with the plans they have selected.

Over the longer term, an Exchange might assess the feasibility of using data and records Exchange ombudsman and Navigator programs accumulate in the course of assisting consumers, evaluating disenrollment patterns, and other ways of measuring plan quality.

From its own tests, CHECKBOOK/CSS has documented that consumers are very interested in ratings of plans by surveyed physicians (CHECKBOOK/CSS has its own instrument for surveying physicians about plans and has done such surveys in many communities), but potential bias issues need to be addressed before surveying physicians about plans they work for.

CHECKBOOK/CSS is committed to making available to anyone implementing an Exchange what it learns in its ongoing user-testing and operation of the quality component of its *Guide* for Federal employees and retirees and what it learns by implementing any comparison tool for any Exchanges for which it has implementation responsibility.

Exchange-Wide Provider Directory

CHECKBOOK/CSS has found that the information of second greatest interest—after information on cost—for consumers choosing among health plans is information on which plans have the consumers' desired doctors as participating providers.

The way plan comparison tools generally answer this question is by referring users to each plan's online provider directory, where the user can look up doctors one plan at a time. That is a cumbersome solution.

CHECKBOOK/CSS has created a model, which it recommends all Exchange's imitate, for an Exchange-wide provider directory that lets the user type in the names of desired doctors and immediately see which plans have doctors with those names (and also to get more information to identify the available doctors in cases where more than one doctor in the local area has the same or similar name).

To create an Exchange-wide provider directory as efficiently and accurately as possible, it will be most efficient for each Exchange to have and exercise the authority to require plans as often as they update their provider directories to provide the entity implementing the plan comparison tool electronic files listing all providers. Once such a reporting system is in place, doing such regular reporting should not be burdensome on plans.

The files listing providers can be required to include fields for various identifiers (NPI, state license number, etc.) that will allow reliable matching of doctors across plans. CHECKBOOK/CSS has much experience, which it is prepared to share with interested Exchanges, on efficient, reliable procedures for merging doctor lists even when plans have limited ability to provide identifiers.

It needs to be recognized, however, that there are inherent imperfections in provider directories; for example, even if doctor matching is done well, there are usability challenges when different plans have somewhat different names for the same doctor and when the doctor is not known to patients by the same name as is used in all provider directories. And users of a directory must be alerted to the importance of contacting the doctor to check that the doctor is still participating in the plans of interest, expects to be participating for the foreseeable future, and is accepting new patients in those plans. But an Exchange-wide provider directory is very valuable in helping plan comparison tool users focus on likely plan candidates.

Provider Quality Information

A plan comparison tool for Exchanges can be enhanced by providing information on the quality and availability of participating providers. Many users coming to an Exchange may need to choose providers and this is an opportunity to help consumers choose high-quality, efficient providers—in the process motivating and guiding providers to improve.

The range of available measurement results at the physician or practice site level is still quite limited. And even the availability of measures that could feasibly be used in the foreseeable future is limited in the arena of outcomes—especially patient-reported outcomes.

An important resource for information on currently available and likely future physician quality measures is the Clinician Measures Workgroup of the Measure Applications Partnership, which was organized by the National Quality Forum under contract with HHS. It is responsible to carry out the ACA requirement that HHS develop clinician quality measure selection principles and a recommended set of clinician quality measures for use by HHS across a range of Federal payment and reporting programs. (CHECKBOOK/CSS is one of the 15 organizational members appointed to this Workgroup. This role has given it an opportunity to get various perspectives on physician quality measures, and has also revealed convenient paths for sharing what it and other organizations learn about the needs and opportunities in Exchanges with the Federal government and other organizations responsible for measure development and dissemination.) It is clear that there is much to be done on this important front.

For the limited purpose of demonstrating and testing how physician quality information might fit within an Exchange, CHECKBOOK/CSS has used its *Guide* for Federal employees to identify lists of physicians who practice in NCQA-recognized Patient Centered Medical Homes and Bridges to Excellence-recognized practices, physicians who have gotten high patient-experience ratings in surveys CHECKBOOK/CSS has conducted of *CHECKBOOK* and *Consumer Reports* magazine subscribers, and

physicians who have been rated high by their peers in surveys of all physicians in their region.

The measures actually used in Exchanges under ACA should meet high standards. These might include the standards of the broadly accepted Patient Charter for Physician Performance Measurement, Reporting, and Tiering Programs. This document requires using National Quality Forum-approved or similar standardized measures wherever available, providing the opportunity for each provider to review results before public release, and other quality controls.

If CMS's PhysicianCompare website becomes the compiler of extensive physician quality information, the kind of best-practices plan comparison tool recommended here might be expected to include information from PhysicianCompare for every doctor affiliated with every plan. This might include information on a wide range of indicators, including board certifications, hospital affiliations, teaching responsibilities, disciplinary actions, performance on measures in the Physician Quality Reporting System, the extent of implementation of electronic medical records to meet Meaningful Use standards, participation in a Patient Centered Medical Home Practice, recognition in NCQA or Bridges to Excellence recognition programs, and other indicators—all presented in ways that will enable consumers to understand their relevance.

Quality and efficiency information should be made available on other types of providers also—for example, information like the risk-adjusted death rates and complication rates and patient survey results for hospitals available in CHECKBOOK's *Consumers' Guide to Hospitals*.

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