Recommended RFP Requirements for a Health Plan Shop-Compare-Select Tool

The health plan shop-compare-select tool within the Exchange must have the following functionalities --

- Provide each user for each available plan a dollar-amount estimate of the average cost for users with similar age, family size, and other characteristics. This estimate should be a total of premium (after any government assistance--detailed premium data for each plan to be provided by the Exchange) plus costs that have to be paid out-of-pocket because of plans' cost-sharing requirements, including deductibles, co-payments, coinsurance, and out-of-pocket limits. The estimates should be based on actuarial analysis using data on expenses incurred by similar populations.
- Provide each user for each available plan a dollar-amount estimate of total cost in high-cost years and low-cost years and an estimate of the likelihood of having such years.
- Provide an Exchange-wide provider directory showing for each available plan the physicians (and possibly other providers) that participate in the plan's network or networks so that the user can enter the names of desired providers and see which plans include those providers in their networks, without having to visit each plan's provider directory separately.
- Provide information on health plan quality using available information on results of member surveys, evaluations of plan wellness and care management programs, measures of provider adherence to medical practice guidelines, rates of disputed claims, accreditation, and other quality indicators.
- Enable users to apply personalized weights or filters to various cost and quality dimensions.

Additional features that will increase the value of such a tool include--

- Provide for each available plan average total cost estimates for users who can predict unusually high health care usage—for example, for a planned pregnancy.
- Provide each user for each available plan a dollar amount for most you can pay out-of-pocket in a year.
- Provide a directory of providers with quality information on each provider, such as whether the provider is in a Patient-Centered Medical Home practice or has met standards for meaningful use of electronic medical records.
- NOT limit the range of plans the user sees prematurely; NOT encourage the user to apply filtering criteria before seeing the cost or quality performance leaders that might be eliminated by such filters. Do provide filtering options that can be used once the full range of plan options has been presented.
- Provide descriptive and evaluative information on special features of each plan, such as dental coverage or acupuncture coverage.
- Be tested with actual users and designed taking into account such user tests.
- Be compliant with Section 508 of the Rehabilitation Act regarding accessibility for persons with disabilities.
- Include capabilities for Navigators, brokers, family members, and others to use it to assist potential plan enrollees.
- Avoid losing users. Provide a simple comparison of plans on the most important dimensions within a few minutes while also enabling users to drill down for more detail.
- Provide a description of benefits and coverage under each plan following the format and language requirements of the Federal-mandated summary of benefits and coverage.

- Provide for each plan standardized "Coverage Examples," much like the Nutrition Facts label required for packaged foods, for at least the two relatively high-cost health care examples required by Federal regulations.

Other capabilities that will be valued in an supplier of a shop-compare-select tool include capabilities to—

- Assist the Exchange authority in defining requirements for each participating health plan to provide comparable, valid, reliable measures of its plan quality.
- Recommend strategies and methods for the Exchange to get measures of plan quality from available sources other than participating plans.
- Provide guidance to the Exchange on using information required to be produced under Section 2717 of the Public Health Service Act on plan or coverage benefits and health care provider reimbursement structures that can be expected to improve patient outcomes, safety, wellness, and other aspects of quality.
- Provide guidance to the Exchange on the collection of valid, reliable information through the member satisfaction surveys required under Section 1311 of the Patient Protection and Affordable Care Act.
- Provide guidance to the Exchange on the collection of standardized, reliable, meaningful information on health plan accreditation.
- Provide guidance to the Exchange on the collection of standardized, reliable, meaningful information on the existence and use of plan-sponsored programs for wellness, care coordination, case management, and other quality improvement strategies of the kinds measured in the National Business Group on Health's eValue8 program.
- Provide guidance to the Exchange on the content, electronic format, and frequency of update of plan provider directories for consolidation into an Exchange-wide directory.
- Provide guidance to the Exchange on strategies and methods for the Exchange to get measures of provider quality.
- Provide guidance to the Exchange on the electronic format and the content of information provided by participating plans on benefits and coverage terms.
- Provide assistance to the Exchange in the design and implementation of surveys and other methods to evaluate the outreach, usability, and impact of the Exchange and of Navigator and other outreach programs.