

Minnesota Health Insurance Exchange Measurement and Reporting Technical Work Group

Meeting Summary

June 11, 2012

I. Welcome

Co-chair Ms. Katie Burns welcomed members back to the Measurement and Reporting Technical Work Group. Ms. Burns provided an overview of the meeting agenda and welcomed guest presenter Mr. Ted von Glahn. Mr. von Glahn serves as a Senior Director and oversees the Pacific Business Group on Health's (PBGH's) efforts to collect, score and use physician, medical group and health plan performance information through several programs including the California Physician Performance Initiative. His current consumer information responsibilities include leading the consumer choice of health plan Exchange research. On behalf of PBGH's members he evaluates health plan and vendor health consumer decision support tools. He has developed a health plan choice decision support application, the PBGH Plan Chooser, for a number of large purchasers to assist enrollees in choosing a plan by considering plan cost, quality, coverage and program services information. Mr. von Glahn joined the work group via webinar.

II. Presentation and Discussion

Mr. von Glahn presented to the work group on "Consumer Choice of Plan Research: Rules to Guide Exchange Decision Support."

Key points included the following:

- The Pacific Business Group on Health (PBGH) is leading a project to help Exchanges set up decision support services to assist consumers in selecting a health plan. This project involves conducting a number of on-line experiments about what matters to people in choosing a plan, difficulties people have in choosing, and decision support techniques to help people make a choice.
- Major findings to date include the following:
 - Choosing the most cost-effective health plan based on an average health care utilization profile is a challenge for consumer audiences. Less numerate consumers are most vulnerable to not choosing the most cost-effective plan.
 - Consumers tend to "overweight" the impact of deductibles and cost-sharing
 - Various plan dimensions matter to different people
 - Doctor/practice choice matters to many
- "Smart defaults" and estimated annual cost at time of care calculators are effective tools in assisting consumers to make more cost effective choices. One key benefit of the estimated annual costs of care is to provide a standardized basis for comparing different health plan choices across different cost sharing structures.
- Eliciting consumer preferences on common priorities (e.g. doctor choice) will help narrow down plan choices to those of most interest to the consumer.

- Limiting the default number of plans from which consumers can choose tends to improve selection of most cost effective plan.
- While summary comparison information is important to guiding decision-making, underlying data must be made available so that consumers can focus on dimensions that are most important to them.
- Benefit design affects results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) enrollee satisfaction survey and Exchanges should account for this in methodologies for quality rating and enrollee satisfaction survey systems.

Work group members had an opportunity to ask questions and provide comments. The following clarifications were provided based on questions from the work group:

- The PBGH experiments focused specifically on costs as this is a primary concern for many consumers. Therefore, the scope of these experiments was narrowed to this particular topic based on consumer interest.
- The cost calculator used in the experiments estimates the cost at time of care given a utilization profile. These costs are based on national data and were tested with a national audience.
- These experiments did include definitions for terminology like deductible and premium within the health plan display. However, the specific language was not tested as a part of the experiments.
- The consumers involved in the experiments were recruited through a marketing firm that provides online panels. Characteristics of participants, like income, were intended to be representative of Exchange users. Participants in the studies had no more than a high school education and income at or below the lowest quartile of income. Additional information will be provided to the work group on the federal poverty level (FPL) and the socioeconomic characteristics of this consumer testing group.

The following issues were discussed:

- Ms. Burns clarified that the Exchange will have a cost calculator and is currently in the process of contracting with an information technology vendor to develop this and other components of the Exchange.
- Consumer aversion to risk influences consumer health plan decision making. For example, a plan with a higher deductible might be more cost-effective, but carries more potential risk for the enrollee. Providing consumers with a cost calculator that allows them to choose varying levels of health care utilization may address this concern as it more concretely provides them with a dollar value or a dollar range to help inform their decision. However, it is important to note for consumers that these dollar amounts are an *estimate* of potential cost of care.
- There are tradeoffs in regards to showing the final premium cost after the subsidy is taken into account versus displaying all of the math that goes into that calculation as a default (e.g., full premium, subsidy amount, and net premium cost to the enrollee).

Exchanges will want to select a vendor with the capability to provide both options as they make decisions on the default display of this information.

- While Exchanges will include components like the cost calculator, navigators will still be important resources for helping consumers select a health plan; some consumers will desire and/or require assistance regardless of the availability and effectiveness of these components.
- In the future PBGH will offer Exchanges a survey that could be used to measure consumer experience with the Exchange decision support tool. For example, did the user's final decision make sense given their selected interests? Additionally, this survey will include other components like the number of users who exit the system without selecting a plan or how many users go to navigators for assistance.
- Future experiments by PBGH will be looking at some of the following factors:
 - The impact on the cost calculator when other defaults are selected, which includes aspects like quality. The experiments will answer the question of how well consumers chose a plan that matches their preferences with or without these defaults. In the future the results of these experiments will be published as potential business rules with statements regarding what is useful and supporting evidence for why it is important.
 - Identification of additional user characteristics that may influence difficulty with plan selection (e.g., characteristics beyond low numeracy skills).
 - To what extent consumers understand and find metal level distinctions useful.
 - Current experiments have not looked at how one might display this data to instill consumer trust but it may be possible to include this component in future work.
- While the PBGH experiments have not looked at presenting cost and quality data, experiments by individuals like Dr. Judith Hibbard have shown that when one frames doctor selection in the context of both cost and quality, this can elicit more thoughtful decision making.

III. Review of Recent Information on Recognition of Accrediting Entities

Ms. Burns reviewed relevant provisions of the General Guidance on Federally-facilitated Exchanges released on May 16, 2012 and a proposed rule released on June 1, 2012 related to recognition of accrediting entities. Ms. Burns noted that the Exchange Plan Certification subgroup will be discussing accreditation for QHPs in their work. However, this accreditation information was provided to the Measurement and Reporting work group since the accreditation process will provide a wealth of data that can potentially be used in the quality rating system.

General Guidance on Federally-facilitated Exchanges

Available online at

http://cciio.cms.gov/resources/files/FFE_Guidance_FINAL_VERSION_051612.pdf

- The guidance notes that the U.S. Department of Health and Human Services (HHS) intends to have a two phased approach to recognition of accreditation organizations. In phase one the National Committee on Quality Assurance (NCQA) and URAC would be recognized accrediting entities on an interim basis subject to conditions. In phase two, HHS would adopt an application and review process for the recognition of additional accrediting entities.
- The guidance suggests that the FFE will accept existing health plan accreditation from NCQA and URAC on issuers' commercial or Medicaid lines of business in the same state in which the issuer is seeking to offer Exchange coverage until the fourth year of certification (e.g., 2016 certification for 2017 coverage year). HHS also intends to propose that QHP issuers without this existing accreditation must schedule this accreditation in their first year of certification and be accredited on QHP policies and procedures by the second year of certification.
- The guidance reports that the Federally-facilitated Exchange (FFE) will display existing Consumer Assessments of Healthcare Providers and Systems (CAHPS) results from accredited commercial and/or Medicaid product lines when these existing CAHPS data are available for the same Qualified Health Plan (QHP) product types dependent on its applicability to adult/child populations. This is applicable for October 2013 enrollment for the 2014 benefit year.
- The guidance also notes the QHP-specific quality rating would be available for display in 2016 open enrollment for the 2017 coverage year.
 - Ms. Burns noted that the Measurement and Reporting work group will continue its work developing a health plan quality rating system for Minnesota, which will need to be submitted to HHS for approval. When rules are released for the quality rating system the Minnesota Health Insurance Exchange will need to make sure its quality rating system fulfills these requirements as well. The Exchange's goal is that its near-term development of a quality rating system will allow Minnesota to provide input into the federal rules to the extent possible.

Patient Protection and Affordable Care Act; Data Collection to Support Standards Related to Essential Health Benefits; Recognition of Entities for the Accreditation of Qualified Health Plans—Proposed Rule

Available online at <http://www.gpo.gov/fdsys/pkg/FR-2012-06-05/pdf/2012-13489.pdf>

- The rule proposes that NCQA and URAC will be the recognized accreditation organizations for the purposes of QHP certification. This approval is effective until it is rescinded or the interim phase one process is replaced by a process intended to be identified in future rulemaking.
- In the future, organizations that wish to be a recognized accreditation organization will follow a recognition process which will include an application procedure, standards for

recognition, a criteria-based review of applications, public participation, and public notice of the recognition.

- The propose rule would require accreditation to occur at the level of an Exchange product type (e.g. Exchange HMO, Exchange PPO, etc.)
- Accreditation entities will be required to share data with Exchanges.
- The Minnesota Departments of Commerce, Human Services and Health are preparing a formal response to HHS on this proposed rule. Ms. Burns mentioned that public comments on any part of this regulation are welcome and will assist the Departments in preparing their formal response.

IV. Wrap Up and Next Steps

Ms. Burns noted that due to a scheduling conflict the work group will either need to reschedule or cancel its July meeting. Additional information on scheduling will be forthcoming.

Next Meeting: Now set for Monday, August 13 from 1:30-3:30 pm.