

**Streamlining the QHP Shopping Experience**  
**A Discussion Paper Prepared by Exchange Staff**  
**July 31, 2012**

While the Affordable Care Act (ACA) considerably standardizes some core features of health plans, consumers shopping for a qualified health plan may still experience difficulty in understanding and comparing variable plan characteristics. Selecting a health benefit plan involves understanding of complex concepts and unfamiliar terminology, and research suggests that many consumers struggle to choose a health plan that provides value while providing a mix of covered services and providers appropriate to their expected health care needs.<sup>i</sup> One of the chief goals of Minnesota's Exchange is to provide a simplified shopping experience complete with decision support aids and support from navigators and call center representatives to help customers select a plan that meets their health care needs.

The purpose of this discussion paper is to briefly describe how one state chose to respond to these decision-making challenges prior to passage of the ACA; to briefly outline how the ACA and subsequent federal guidance affect the extent to which basic features of health benefit plans are and will be more standardized; to describe the high level approach Minnesota intends to take related to the development of decision support tools and other consumer information; and to describe a standard HHS intends to use in Federally facilitated exchanges to address variation between plans offered to consumers. These topics are presented to stimulate discussion about the extent to which it may be useful from a consumer perspective to further standardize certain QHP characteristics as well as other strategies for helping consumers understand differences between QHPs. The paper concludes with several broad discussion questions related to strategies for streamlining the QHP shopping experience.

#### **Standardized Cost Sharing In Massachusetts**

A few years after its inception in 2007, the Massachusetts Health Connector convened user focus groups to provide feedback on the overall experience of shopping for plans on the Connector. Plans sold in the Connector were organized into actuarial metal levels similar to those required under the ACA and were required to meet existing state mandates that were less robust than the benefit standards required under the ACA. Focus group participants reported considerable confusion when choosing between available plan options. In response, the Health Connector standardized cost sharing structures to simplify the experience of shopping for plans. Coverage currently offered through the Massachusetts Connector includes multiple plan and provider network offerings within six different standardized cost sharing structures.

#### **Benefit Standardization in the ACA**

The ACA creates a floor for benefits that must be included in individual and small group market plans through the creation of the Essential Health Benefits (EHB) set. Beginning in January 2014, all non-grandfathered health plans in the individual and small group markets must include coverage of the ten following EHB categories:

- Ambulatory Patient Services
- Emergency Services
- Hospitalization
- Maternity and newborn care
- Behavioral health and substance abuse treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric dental and vision care

While some variation in covered services may exist within and potentially across these broad categories, these requirements will help ensure that health plans both in and out of the exchange include coverage of these basic services.

### **Actuarial Value and Cost Sharing**

In addition to the essential health benefit requirements, plans must fall into one of four metal tiers consistent with the actuarial value of the plan. Actuarial value is defined as the average percentage of health care costs covered by the plan. A bulletin issued by the U.S. Department of Health and Human Services (HHS) in February 2012 on actuarial value calculations and cost sharing indicates carriers will have flexibility to structure cost sharing features (deductibles, co-pays, etc.) as long as the plan's actuarial value is equal to one of the four specified metal levels and otherwise meets federal requirements. HHS described the approach it intends to use to calculate actuarial value using a standardized data set.<sup>ii</sup> Using a consistent data set and common methodology to calculate actuarial value allows consumers to more readily and uniformly compare the average proportion of costs covered by a carrier vs. the average proportion of costs covered by a consumer.

In addition, as required by the ACA, all preventive services are exempt from cost sharing, and plans must cap the maximum out of pocket costs for enrollees at the same level as plans paired with a Health Savings Account, currently \$5,950 for individuals and \$11,900 for families.

### **Decision Support Tools Under Development in Minnesota**

The Exchange in Minnesota will develop decision support tools to help consumers find a health benefit plan that best meets their needs. This decision support tool will allow consumers to prioritize among all QHP options available to them by offering consumers the ability to search for plans with certain desired characteristics, such as whether a provider is available within a QHP network or according to quality ratings, among other search criteria. The state's information technology vendor will also build a total cost of care calculator to assist consumers in comparing total estimated costs of care across different QHPs. The state intends to build on national research, findings and recommendations from the UX2014 project as well as the Pacific Business Group on Health and Consumers Union to design an optimal

consumer choice architecture. Effective decision support tools can streamline the consumer shopping experience by presenting a more manageable number of choices that are more tailored to a consumer's preferences. It is the goal of the Exchange in Minnesota to offer easily comparable metrics and information about QHP options to further support the consumer decision-making process.

### Meaningful Difference Criteria in Federally Facilitated Exchanges

Recently issued guidance on the Federally facilitated Exchanges includes an overview of state partner plan management functions. The plan management functions include review of plan offerings by issuer for "meaningful differences" between the plan offerings to ensure that a manageable number of distinct plan options are available to consumers.<sup>iii</sup> Medicare Advantage operations guidance includes specific criteria for evaluating meaningful differences between Medicare Advantage Organizations to ensure beneficiaries can easily identify the differences between plans and determine which plan provides the best value. The Centers for Medicare and Medicaid Services uses plan specific per member per month (PMPM) out of pocket cost estimates to evaluate meaningful differences between plan types (HMO, PPO, etc.). According to program guidance, there must be a difference of at least \$20 PMPM between the out of pocket costs for each plan offered by the same issuer in the same county for the plans to be considered meaningfully different.<sup>iv</sup>

### Considerations for Streamlining the QHP Shopping Experience in Minnesota

1. What role, if any, should the Exchange play in ensuring meaningful differences exist among QHP choices offered to consumers during the QHP shopping experience in Minnesota? What are the advantages and disadvantages of the Exchange playing such a role?
2. What other strategies may be employed to streamline the shopping experience and help consumers understand and compare differences between plan choices?

---

<sup>i</sup> Pacific Business Group on Health, "Consumer Choice of Health Plan: Decision Support Rules for Health Exchanges," July 2012.

<sup>ii</sup> United States Department of Health and Human Services, Actuarial Value and Cost Sharing Bulletin, February 2012.

<sup>iii</sup> Centers for Medicare and Medicaid Services, "General Guidance on Federally-facilitated Exchanges," p. 10, May 16, 2012.

<sup>iv</sup> Contract Year 2013 Medicare Advantage Bid Review and Operations Guidance, Centers for Medicare and Medicaid Services, April 12, 2012.