State Health Insurance Exchange Websites:

A Review, Discussion and Recommendations for Providing Consumers Information about Quality and Performance

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I. INTRODUCTION

A centerpiece of the recently enacted health reform legislation—the Patient Protection and Affordable Care Act (ACA)—is the creation of state-level health insurance exchanges. The exchanges must be certified by the Department of Health and Human Services (DHHS) by January 1, 2013 and fully operational by January 1, 2014. They are to provide a “one-stop” place for individuals and small employers to learn about their health insurance options and purchase the plan that best meets their needs. By design, they should offer a structured way to compare health insurance plan premiums, benefit packages, cost-sharing, and quality in order to facilitate a purchase decision. A key element of their success will be the extent to which consumers and small employers find the purchase experience to be informative and easy.

While the exchanges must undertake many important activities, those that relate to the consumer shopping and purchase decision include:

- Deciding which plans to offer
- Maintaining a website that provides plan information in a standardized format
- Operating a toll-free hotline
- Establishing a navigator program to assist consumers

This study addresses the second health exchange function: maintaining a website—with a particular focus on information about health plan quality and performance that could be made available to the public to help them select a plan. To inform the decisions states will make about the content and appearance of their websites, this study examines the current “state-of-the-art” of online consumer-oriented health plan report cards available in states and nationwide. These report cards bring various types of quality, patient experience of care and other organizational information into one consumer-oriented report available through the Internet. They usually provide information on several aspects of performance for different types of managed care plans including Health Maintenance Organizations (HMOs), Point-of-Service Plans (POS) plans, combined HMO/POS plans and sometimes Preferred Provider Organization (PPO) plans.1

The exchanges can play a key role in ensuring that consumers (individuals and families as well as small business purchasers) will have information they’ll need to make informed decisions in selecting health insurance options. Several principles should guide their work:

- Information provided by exchanges should be easy to understand and use.

1

Typically, information about quality is not available for fee-for-service programs. In the commercial sector, managed care plans are the dominant insurance model. However, in Medicare, the Medicare Advantage plans (which are largely managed care plans) represent only about 25 percent of the market. Information on quality in the Medicare program is generally available only for the Medicare Advantage plans.
The quality of health plans offered through the exchange should be measured and publicly reported based on accepted national standards.

Decision-support tools and “plain language” educational materials should be available to assist consumers.

Consumers should be involved in all aspects of exchange website design—including testing performance report formats and site navigation to assure accessibility and understanding.

**Report Overview**

This report first summarizes the ACA requirements for the health insurance exchange websites. It then provides a brief overview of managed care measurement systems that are typically used to evaluate the quality of care in health plans, including the experience of care as reported by health plan members. The methodology section details the review of 70 websites in six categories. Findings describing the content of the report cards on the following topics are then presented:

- Number of Health Plan Choices Available to Consider
- Health Plan Quality and Patient Experience of Care
- Information on Complaints, Grievances, Appeals, Medical Loss Ratios and Executive Compensation
- Other Types of Performance and Cost/Payment Information
- Education and Decision Support
- Integration of Information About Physicians, Hospitals and Other Health Providers

At the conclusion of each section, there is a brief discussion of issues raised by the findings and a set of related recommendations. For the ease of readers most interested in the recommendations, the concluding section contains a complete listing of all recommendations. In addition, to inform the decisions exchanges will make when they begin operations, a prioritized list of the types of performance information that should be made available by health insurance exchanges is also provided in the recommendations section. Finally, screenshots of sample websites and an appendix of all of the managed care report card websites reviewed for this study are also provided.

**Purpose of this Study**

The main purpose of this study was to determine the content of public reports on health plan quality and performance, based on selected report cards from the database of the Informed Patient Institute (IPI), a non-profit organization dedicated to providing consumer access to credible online information about quality and patient safety. The study sought to identify the types of information health plans currently report that might inform what exchanges websites will post when they first begin operations. It is noteworthy that while consumers and purchasers have a great interest in having plan-specific information on the cost of care, most of the report cards reviewed (which were primarily sponsored by states) did not include actionable cost information—such as premiums or out-of-pocket costs—that should be an essential part of health insurance exchange website information. Therefore, due to the paucity of publicly-reported information on cost, this important dimension of public reporting is addressed only to a limited extent in this report.

In addition, there may be other types of quality information presented by private or public employers to convey plan performance to their employees, dependents and retirees during open
enrollment periods. Further research on these efforts to determine other areas of consumer-oriented performance information that should be available through health insurance exchanges is strongly recommended.

II. HEALTH INSURANCE EXCHANGES AND PERFORMANCE REPORTING

The ACA requires state health insurance exchanges to maintain an Internet website through which consumers can get standardized comparative information on plans. Exchanges also must assign a rating to each qualified health plan offered. DHHS is tasked with developing a system that rates health plans on the basis of their relative quality and price.

The website must also include the results of plan enrollee satisfaction for plans that had at least 500 enrollees in the previous year and establish and make available a calculator to determine the actual cost of coverage. The legislation notes that the Secretary will develop a model template for an Internet website to assist consumers in making health insurance choices.

Health plans offered by the exchange must be accredited based on their local clinical quality and patient satisfaction results as well as consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access and patient information programs. Accreditation must be done by an entity recognized by the Secretary that has transparent and rigorous methodological and scoring criteria.

In addition, the plans must disclose information on:

- Claims payment policies and practices
- Periodic financial disclosures
- Data on enrollment
- Data on disenrollment
- Data on the number of claims that are denied
- Data on rating practices
- Information on cost-sharing and payments with respect to any out-of-network coverage.
- Information on enrollee and participant rights under this title
- Other information as determined appropriate by the Secretary.

The law requires that this information shall be provided in plain language noting that “plain language” means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise and well organized. It requires that the DHHS Secretary and the Secretary of Labor jointly develop and issue guidance on best practices of plain language writing.

Upon request, health plans on the exchange must provide information on the amount of cost-sharing (including deductibles, co-payments, and coinsurance) for which individuals are responsible in terms of specific items or services rendered by a participating provider. At minimum, such information shall be made available through an Internet website or other means for individuals without access to the Internet. Finally, as part of the certification process health plans must:
Provide information on health plan quality measures to enrollees and prospective enrollees, and to each exchange in which the plan is offered.

Prominently post on their website premium increase justifications prior to their implementation.

Health insurance exchange sponsors will need to address at least three aspects of providing information to the public: 1) What quality and performance information is integrated into an online health insurance exchange plan report card that consumers see as they review their plan options and choose a specific plan; 2) What other types of plan performance information is publicly available from the exchange, but not integrated into the selection website; and 3) What types of information should be publicly disclosed by the plan itself rather than on the exchange. Recommendations presented at the end of this report offer suggestions that address these questions.

III. MEASURING THE PERFORMANCE OF HEALTH PLANS: A BRIEF HISTORY

HEDIS: Accompanying the growth of managed care in the late 1980s and 1990s was the development of a performance measurement system now called the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS measures capture information about the care delivered in health plans in a wide range of areas, such as preventive care, diabetes care, or heart care. The National Committee for Quality Assurance (NCQA), an accreditor of managed care plans, is the steward of HEDIS and as such, ensures that the measures remain consistent with current evidence, maintains a database of HEDIS performance scores, and provides technical support for HEDIS users. A Medicaid and Medicare HEDIS was also developed to capture performance information about those populations, but no longer exists as a separate measurement set. Now the same measures are used and the results are stratified by type of coverage (i.e., Commercial, Medicare, Medicaid).

CAHPS: Another major measurement tool was developed by the federal Agency for Healthcare Research and Quality (AHRQ) in the mid-1990s. This validated tool, called the Consumer Assessment of Healthcare Providers and Systems (CAHPS), is a patient survey that assesses performance from the enrollee’s perspective in areas such as getting needed care, getting care quickly or how well doctors in the plan communicate. CAHPS and HEDIS are used by NCQA to measure and accredit health plans. CAHPS surveys are available at several units of analysis, such as the health plan, clinician/group, hospital, and nursing home levels. Each level could potentially be useful for reporting patient experience in the exchanges. However, because this study examined managed care report cards, only information on the availability of health plan CAHPS is considered.

State agencies responsible for licensing HMOs and other types of health plans, such as State Departments of Health, often require the collection and reporting of HEDIS and CAHPS information as part of their oversight of these organizations. Another state agency—the Departments of Insurance generally collects other types of information about health plans, such as complaints, grievances, appeals and financial information.
Early managed care report cards comparing multiple plan options were available to employees and dependents of large employers. Local employer coalitions also made report cards available to their employer members and their employees. States such as Florida, Maryland, Michigan, Minnesota, New Jersey and New York printed and made publicly available HMO performance reports as early as the mid-1990s. The growth of the Internet at that time allowed many of these reports to become more accessible and their availability has grown. Now, managed care report cards are published by a variety of sponsors including federal and state regulatory agencies, public and private purchasers, and employer, consumer, and community groups. They are often featured as a resource during annual “open enrollment” periods when consumers have the opportunity to consider their health insurance choices for the coming year.

IV. METHODOLOGY

This report analyzed 70 managed care report cards during the period October-November 2010. Seven of the report cards offered information about health plans available nationwide, while 62 provided information from 34 different states and one at a regional level (Puget Sound, WA). The report cards were drawn from the IPI database, which was initiated in 2007 when IPI staff identified a wide range of online report cards—including those pertaining to managed care plans—by conducting a state-by-state and national analysis. Since that time, the IPI database has been maintained and updated. A list of all of the report cards reviewed for this report is available in the appendix.

In general, the managed care report cards reviewed provided information from 2009 – 2011. Ten report cards provided information prior to 2009, with the oldest from 2006. Most were free, though permission was granted to review two subscription sites: Consumers’ CHECKBOOK's Guide to Plans for Federal Employees and Annuitants and Consumer Union's Consumer Reports on Health Insurance. Most were designed for consumers—although a small number were more oriented to health policy makers or employers.
As indicated in Figure 1, several types of managed care report card sites were reviewed that varied by sponsor or scope:

<table>
<thead>
<tr>
<th>Type of Report Cards</th>
<th>No. Reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Insurance Departments</td>
<td>25</td>
</tr>
<tr>
<td>State Health Departments</td>
<td>15</td>
</tr>
<tr>
<td>Medicaid</td>
<td>7</td>
</tr>
<tr>
<td>Non-profit Community Collaboratives</td>
<td>5</td>
</tr>
<tr>
<td>National Report Cards</td>
<td>5</td>
</tr>
<tr>
<td>Public Employer</td>
<td>5</td>
</tr>
<tr>
<td>Employer Coalition</td>
<td>4</td>
</tr>
<tr>
<td>Health Insurance Exchanges</td>
<td>4</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>70</strong></td>
</tr>
</tbody>
</table>

State Department of Health or other state health organization report cards – These report cards provided a range of quality, patient satisfaction, and other types of information about a state's HMOs, HMOs/POS, and, sometimes, PPO plans. They were most often sponsored by a state health agency such as the State Department of Health (15 sites). Other types of sponsors included non-profit community collaboratives made up of stakeholders from multiple sectors, such as the Wisconsin Collaborative for Healthcare Quality (5 sites) and employer coalitions (4 sites). One site, the New York State Health Accountability Foundation, provided report card information in multiple states (Connecticut, New Jersey, New York, Rhode Island, and Vermont). Twenty-four of these sites were reviewed.

State Department of Insurance report cards – These sites provided information reflecting a Department of Insurance's regulatory oversight of its state's health insurance plans, such as data on complaints, grievances, appeals and financial information. The sites provided information about a wide range of health insurance products besides managed care plans, such as individually purchased health insurance and Medigap (i.e., Medicare supplemental insurance). They also included information on other types of insurance such as auto or homeowners insurance. Twenty-five of these sites were reviewed.

Report cards providing information nationwide – These five sites offered information about plans nationwide. The nationwide sponsors included federal agencies, such as the federal Department of Health and Human Services (DHHS) and the Centers for Medicare and Medicaid Services (CMS), as well as non-profit organizations, such as the National Association of Insurance Commissioners (NAIC), NCQA, and Consumers Union.

Health insurance exchanges – Websites for the two current health insurance exchanges were reviewed: the Massachusetts Health Connector and the Utah Health Exchange. In addition, the website for a small business membership organization, the Connecticut Business and Industry Association, was reviewed. The Wisconsin Health Insurance Exchange has posted a prototype website with fabricated information that was also reviewed.

Public employer health plan information - Five managed care report cards issued by public employers were reviewed: the Federal Employee's Health Benefit Program (FEHBP) (providing information nationwide); and three state employee benefit programs in California (CalPERS),
Maryland, and Wisconsin. Consumers’ CHECKBOOK's *Guide to Plans for Federal Employees and Annuitants*, which is available by subscription, was also reviewed.

**Medicaid report cards** – Seven Medicaid report cards were reviewed for California, Maryland, Michigan, Pennsylvania, South Carolina, Virginia and Wisconsin.

**V. FINDINGS: REPORT CARD VARIABLES**

**A. Number of Health Plan Choices Available to Consider**

One function of the exchanges that affects the shopping and purchasing decision is the number of health insurance plan choices available to consumers for consideration. Too many choices can overwhelm decision making, while too few can limit an individual’s ability to match his needs to an insurance option. Some also argue that if too few options are offered, the benefits of market competition are reduced.

The number of choices available to consumers reflects differences in health care markets. In some parts of the country (or even within states), there will be more choice than in other areas. To illustrate these differences, we sought information about commercial managed care plans from two national report card sites, NCQA and Consumers Union, for Maryland and Wyoming. We found information for 10-13 plans in Maryland compared to just 2-3 in Wyoming.

When deciding on a health plan, there are at least three different aspects a consumer must consider, each of which can affect quality and other performance issues to a greater or lesser extent. These aspects are: the benefit package, type of health plan, and company offering the plan. At the highest level is the company or corporation offering the health plan. Insurance companies may offer plans in many or all states, such as Aetna, CIGNA, or UnitedHealthcare, or in one state or region, such as a Blue Cross Plan, or Kaiser Permanente. In some cases, a health plan may just serve a local market.

The next level of choice involves the types of health plans that are available, whether an Health Maintenance Organizations (HMO), a Point of Service (POS), a Preferred Provider Organization (PPO), or some other type of plan. The third, and probably most important, level of choice is the actual benefit package offered—the combination of co-pays, deductibles, and benefits covered. For example, the Massachusetts Health Connector Exchange structures choice by benefit level—the “Bronze”, “Silver” or “Gold” plans (also required in the ACA).

**Number of organizations for which information is presented in report cards**

The reviewed report cards varied significantly in the number of entities that were included in the report. State health report cards varied from the two plans reviewed in the Rhode Island state report card to over 60 in the Wisconsin Health Plan Report. The typical state report card included 8-10 plans. These report cards provided information only at the highest organizational level—by product line at the corporate level. For example, the Maryland Health Plan Performance report presents information about seven combined HMO/POS plans in the state (Aetna, Carefirst BlueChoice, CIGNA, Coventry, Kaiser, MD-IPA and Optimum Choice) and three PPO plans.
(Aetna, BluePreferred, and Connecticut General Life Insurance Company). Information that is aggregated at the state-level can obscure local performance levels. Thus, consumers seeking information about care in their local areas may not necessarily be able to draw valid conclusions from state-wide reports.

Many of the state insurance department websites included information on dozens or hundreds of insurance companies in the state—including health insurance companies. In some cases, they indicated which of the health insurance companies were HMOs or other managed care plans, in other cases, it was not possible to determine the type of health plan.

**Number of plan options/benefit options**

To assess the range of choices that are available at the plan and benefit option level, six report card sites were reviewed in some detail. These sites more closely mirror what consumers using the exchange likely will experience. These sites were: the FEHBP program, Healthcare.gov (utilizing the section on health insurance plans for individuals and families), the Medicare Plan-Finder, CalPERS, the Massachusetts Connector, and the Utah Health Exchange.

To conduct this assessment, in December 2010 and January 2011 sample data for an individual looking for health insurance in Maryland and Wyoming were entered into the Medicare Plan-Finder, Healthcare.gov and the FEHBP site; data were also entered in the Massachusetts Health Connector site for an individual from Boston and Pittsfield (a more rural city in Western, MA). The CalPERS and Utah sites offered statewide options that did not vary by area.

As indicated in **Figure 2**, the two sites offering the highest number of choices were the Healthcare.gov private health plan offerings in Wyoming (86) and Maryland (80). These results included all types of health insurance options—not just managed care plans.

Medicare (with 41 plan benefit options in Maryland and 39 plan options in Wyoming) and the Massachusetts Health Connector (with 42 options in Boston, MA and 29 in Pittsfield, MA) offered the next highest number of plan options. The Federal Employee Health Benefit Plan offered a more moderate set of choices, with 17 plan choices in Maryland and 13 in Wyoming.

At the other end of the spectrum, Cal-PERS offers six choices to their employees statewide—three HMOs and three PPOs (excluding association plans only open to certain populations). The Utah Health Exchange does not list benefit plan options to individuals and families, but rather directs potential purchasers to the “Get a Quote” sections of one of five health plans that offer coverage in the state. It also provides links to websites that provide side-by-side comparisons of health insurance options.
Figure 2: Number of Health Plan Offerings Available Across Six Selected Sites

<table>
<thead>
<tr>
<th>Name of Site</th>
<th># of plan offerings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare.gov- WY</td>
<td>86</td>
</tr>
<tr>
<td>Healthcare.gov-MD</td>
<td>80</td>
</tr>
<tr>
<td>MA Healthconnector-Boston</td>
<td>42</td>
</tr>
<tr>
<td>Medicare-MD</td>
<td>41</td>
</tr>
<tr>
<td>Medicare-WY</td>
<td>39</td>
</tr>
<tr>
<td>MA Healthconnector-Pittsfield</td>
<td>29</td>
</tr>
<tr>
<td>FEHBP-MD</td>
<td>17</td>
</tr>
<tr>
<td>FEHBP-WY</td>
<td>13</td>
</tr>
<tr>
<td>Cal-PERS</td>
<td>6</td>
</tr>
<tr>
<td>UT Health Exchange (links)</td>
<td>5</td>
</tr>
</tbody>
</table>

Discussion and Recommendations

Offering the “right” level of choice for consumers as they consider their health insurance options will be a challenge. This challenge is related to the larger policy decision about whether health insurance exchanges will offer every plan that meets their criteria or be more selective purchasers and offer fewer plans chosen on the basis of even more competitive criteria. It is instructive that some of the most oft-cited large purchasers—FEHPB and CalPERS—offer more limited choice of health plans than other report card sponsors reviewed. One could have a strategy to narrow plan offerings over time after gaining experience on the quality of the options available as well as how consumers navigate the available choices. A downside of this strategy however, is that individuals and families who have existing provider relationships could be forced to change health plans and therefore have their care relationships potentially disrupted.

To assist with choice, exchanges should build in tools and resources that help users narrow their choices. As will be further detailed later, plan selection tools can assist in this task by taking consumers through a process of considering their options and eliminating those that do not match their personal preferences. Another tool used by some of the reviewed websites, such as Medicare's Health Plan Finder and Healthcare.gov, is one that allows users to sort or narrow their choices based on specific criteria, such as out-of-pocket limits, annual deductible, monthly premium, quality, or doctor choice.

The multiple layers of the health plan choice adds complexity and confusion to the decision making process as one is making a choice of a company, a type of plan (HMO, PPO) and a specific benefits package (e.g., Bronze, Silver, Gold). The same companies offering plans through the exchange may be offering other health plan products outside the exchange and to different populations, such as Medicare or employers. Trying to minimize confusion by standardizing as much as possible the names of products is one strategy that could be considered. For example including in the product name the name of the company, the type of product and the annual deductible, such as Tufts Bronze
RECOMMENDATIONS:

- Consider the burden of consumer decision making in deciding how many health plans to offer. In general—fewer, rather than more, choices will assist in decision making.

- Include tools and resources to assist consumers in narrowing choices.

- Minimize consumer confusion by considering ways to standardize and “name” health plan benefit package options.

B. Health Plan Quality and Patient Experience of Care

HEDIS Scores and Information on Accreditation

A little over one-half of the reviewed sites (53% or 37 sites) included HEDIS quality information in the managed care report card. Almost all of the national, state level and Medicaid report cards report information on HEDIS measures, while only a few of the state insurance department report cards included HEDIS information.

There was variation in the breadth of HEDIS information conveyed in the report cards. As will be further discussed below, some report cards rolled up all HEDIS information into one overall score. Others included a wide range of individual measure results. Some do both. For example, the New York Health Accountability Foundation report cards included 32 separate HEDIS measures, the California Office of the Patient Advocate included 29, the FEHBP program included 23, and the Utah state report card included 21. Medicare's report card provided both a rolled up score and information on 21 individual HEDIS scores. When published on a web page, the user viewing an overall score can easily drill down to see the individual scores, if he is interested in more granular information.

The most commonly reported HEDIS measures in the reviewed report cards were largely measures that indicate whether a particular clinical process had been conducted, such as: breast cancer screening, diabetes care measurements, blood pressure screening, and cervical cancer screening. Medicaid report cards included more pediatric measures and measures of particular interest to that population such as lead screening and dental visits. Medicare's report card included measures applicable especially to older adults, such as glaucoma testing or prescriptions for rheumatoid arthritis medications.

Twenty of the managed care report cards reviewed included accreditation status which was primarily NCQA accreditation, but also included URAC, and the Accreditation Association for Ambulatory Health Care (AAAHC).
Patient Experience of Care

Similar to the HEDIS findings, 36 plans (51%) reported CAHPS patient experience of care information. In many cases, managed care report cards included both HEDIS and CAHPS information, though a few included one and not the other.

Information about CAHPS information was presented in a variety of ways ranging from a rolled-up summary score to reporting by individual CAHPS questions. The results seen most often included these questions and composites:

- Overall rating of the health plan
- Getting care quickly
- Getting needed care
- How well doctors communicated

Presentation Frameworks for Quality and Patient Experience of Care Information

Report cards used a variety of frameworks to organize the presentation of their quality information. Seven of the report cards reviewed simply presented results for each HEDIS or CAHPS measure individually. Most of them, however, used some type of framework to sort the performance measures into categories. These categories included:

- Disease or condition categories such as “Heart” or “Cardiovascular care”, “Diabetes”, or “Mental health”
- Demographic categories such as “Women's health” or “Children's health”
- Type of measure categories such as “Access/Availability”, “Effectiveness of care”, or “Member satisfaction”
- Broad health categories such as “Preventive care”, “Acute care”, “Chronic care”, or “Behavioral health”
- Broad health categories described in “plain language” such as “Staying healthy”, “Getting better” or “Living with illness”

Many report cards used several topic headings to convey performance results in different areas and included some disease categories, some demographic categories, and some type of measure categories. For example, topics on the Louisiana Health Finder (http://www.healthfinderla.gov/CQHealthPlans.aspx) included: “Customer satisfaction”, “Diabetes care”, “Maternity care”, “Medical care”, “Women's health” and “Youth care”.

NCQA used a broader framework: “Access & Service”, “Qualified providers”, “Staying healthy”, “Getting better” and “Living with illness”. (See Screenshot #1) This same framework is used in other reports such as:

- The Michigan HMO Consumer Guide
- The New York Consumer Guide to Health Insurers (slightly modified)

- The Massachusetts Health Connector (See Screenshot #2)
The Medicare Plan Finder (See Screenshot #3) used the following framework: “Staying healthy”, “Managing chronic (long term) conditions”, “Ratings of health plan's responsiveness and care”, “Health plan member complaints and appeals”, and “Health plan's telephone customer service.”

**How Report Cards Convey Plan Performance: Use of Easy-to-Interpret Methods**

There were a variety of methods used to convey how well managed care plans did in comparison to one another or to a benchmark. The use of these methods is intended to help the user determine quickly how to interpret performance and draw the right conclusion about top or poor performers.

The most common format used to present performance results in the managed care report cards were stars and bar graphs. Most star rating systems used either 1-3 stars or 1-4 stars to convey relative performance—with more stars generally conveying higher performance. The Medicare Plan Finder, however, used a 5-star rating system with 5 stars being excellent, 4-above average, 3-average, 2-below average and 1-poor. The Medicare Plan Finder also included a Caution Symbol (an exclamation point in a red triangle) for plans that had earned three stars or fewer for three years in a row. To reinforce the caution symbol, an explanatory note was included: “If you are considering enrolling in this plan, look closely at the detailed ratings for this plan.”

Other less common methods included:

- Charts with percentages and numbers
- “Consumer Reports”-type circles
- Checkmarks
- Up/Down arrows
- Grades (A-D)
- Words such as “Higher than average”, “Average”, “Lower than average”
- Color/Shading (green to indicate better performance/red-poor performance)
- Rank ordering – with best plans appearing first
- Functionality to permit sorting results based on performance

One report card sponsor (Maryland Health Care Commission) indicated the total number of measures where the plan had an “above average” score within four measure categories. For example, one plan (Kaiser Permanente) had six measures with above average scores in the measure categories of “member satisfaction”, “preventive care”, “chronic care” and “behavioral health”.

Some reports used more than one method to convey relative performance. For example, the South Carolina Medicaid Health Plan rating used green shading to accentuate the 3-star (top) rated plans.

A few report cards included an “overall plan rating or score” that combines sub-scores into one or a few overall numbers. These included:

- Consumer Reports uses an overall score on a scale of 1 to 100. The three components of the overall score are prevention and treatment (60% of score), enrollee satisfaction (25% of score), and NCQA accreditation (15% of score). They also include subscores on Consumer
Satisfaction, Prevention and Treatment using a “1” to “5” scale, “1” being worse than average and “5” being “better than average”. The rankings and ratings are based on data and analysis from NCQA through a new publishing arrangement between the two organizations.

- The Massachusetts Health Connector includes an overall score based on NCQA’s accreditation score in addition to subscores for HEDIS results that are presented using the same framework that NCQA uses: “Access & Service”, “Qualified providers”, “Staying healthy”, “Getting better” and “Living with illness”. Interestingly however, report card information is not available for plans offered through the Commonwealth Care program for lower income uninsured residents.

- Medicare Plan Finder: Uses a 1-5 star overall plan rating that is prominently displayed on the results page. The rating combines up to 53 measures in up to 5 categories (Staying healthy, Managing chronic conditions, Ratings of health plan's responsiveness and care, Complaints and appeals and Telephone customer service) depending on the type of plan under consideration.

- **WI State Employees Decision Guide**: Uses an “Overall Quality Score” that is conveyed using 1 to 4 stars. It includes sub-score measures in each of the following areas: wellness and prevention, behavioral and mental health, disease management and consumer satisfaction and experiences based on HEDIS and CAHPS measures. Details about the sub-scores are also available. (See Screenshot #4)

### Benchmarks

Just under one-half of the reports reviewed compare plan performance to benchmarks: thirteen sites use national averages for comparison, while 10 sites used state averages. Many of these showed both national and state benchmarks. Other less commonly seen benchmarks included regional averages (such as for New England) or “best performing” or “90th percentile” performance regionally or nationwide.

Some report card sites also provided information on trends—how well the plans have done over time. They offered users the option to click into information from previous years. The report card for Wisconsin state employees included an “up” or “down” arrow indicating whether the plan “had statistically significant improvement in their score” from one year to the next.

### Discussion and Recommendations:

Collecting and making available information about the quality of health plans will be an important role of the health insurance exchanges. HEDIS and CAHPS information has long been collected by a variety of health plan overseers and is well suited to being used by health insurance exchanges to differentiate health plan performance. The measures are evidence-based, circulated for public comment, and maintained for currency by a highly-respected measure steward. Therefore, ideally, HEDIS and CAHPS information will be prominently featured by health insurance exchanges in the first place on the website consumers go to compare information. For example, Medicare includes
information about each plan's overall plan rating on the same page that it provides information about the costs of the plan.

In addition, the way in which quality and patient experience information is conveyed should be quickly interpretable and should include an overall score—or only a few higher level scores for each plan. Users who want more information can be given the option to dig deeper for more details if they desire. Designing information so that the user can clearly see “at-a-glance” who is the best or better performers using symbols such as stars, grades, words such as “Better”, “Poorer” or colors will make the information easier to use. Other methods of making information easier to interpret such as rank ordering health plans by performance (or rank ordering within cost bands) or offering the ability to sort health plans based on a factor of interest to the user could also be considered.

For those consumers who want to dig deeper and learn more about the underlying measures and performance, creating an organizing framework for that information by disease or some other easily understood categorization scheme will assist in using the information. Creatively thinking about how certain types of more detailed information might be used is another option. For example, HEDIS measures about the quality of maternity care (pre-natal and post-partum care) could be featured near the health plan benefits section describing the plan's maternity benefits. Similarly, information about performance on chronic care could be featured near the descriptions of those benefits.

In designing report cards and scores based on measures, efforts should be made to help differentiate the plans on the basis of their performance. One way is to set “stretch” goals for health plans in the quality arena so that plans that excel by performing well stand out. Rather than design a scoring system where all health plans are compared to an “average” performance benchmark, they could be compared to stretch goals—such as the top 10% of plans in the state or nation. This approach will also motivate plans to improve.

Enrollees and potential enrollees in health plans must be able to trust that the information they are viewing reflects the performance of the plan that they are enrolling in. This will be determined by the entity being measured—whether at the corporate organization level, the plan-type level (e.g., HMO vs. POS vs. PPO) or the benefit package level. Measuring at only the corporate level might mask important differences among plan types. On the other hand, measuring at the benefit package level might not be feasible, given smaller numbers of enrollees. Measurement should occur at the level closest to that reflecting the actual plan performance that consumers’ experience that is both feasible and that captures differences amongst plan types.

In designing health insurance exchange health plan information, efforts should be made to include users in the design phase of the information and to test the formats with potential users to ensure that they understand and can navigate the information.

**RECOMMENDATIONS:**

- Include information on health plan quality based on nationally endorsed measures, particularly HEDIS and plan member experience of care based on CAHPs, in information conveyed about plan performance.
• Feature plan quality and patient experience of care as prominently as other aspects of plan information, such as costs.

• Ensure that plan quality information can be interpreted “at-a-glance” with the option for users to dig deeper in areas of interest if desired. Use an organizing framework to categorize more detailed information.

• Consider using “stretch” benchmarks or other approaches when creating plan quality scores that will both motivate improvement and show variation among plans.

• Measure plan performance at the level closest to that reflecting the actual plan that consumers enroll in that is both feasible and that captures differences amongst plan types.

• Include users in the design of health insurance exchange websites.

• Test the design to ensure its usefulness and navigability to a range of consumers.

C. Information on Complaints, Grievances and Appeals, Medical Loss Ratios and Executive Compensation

There are several types of performance information about health plans that are generally available from state insurance departments including complaints, grievances, appeals, medical loss ratios (the amount of a premium dollar spent on medical claims vs. administrative costs) and executive compensation. This information is generally required to be reported to the state as part of their regulation of insurance, though states vary as to whether and how it is reported to the public. Typically, it is not integrated with information on the HEDIS and CAHPS results noted above, and, frequently, it is neither presented in easy to read formats, nor is it easy to find.

Complaints, Grievances and Appeals on State Websites

There were several types of information on complaints, grievances, and appeals found in the reviewed report cards. The information generally fell into one of the following three categories:

➢ Information about issues or actions “inside” the plan. These are complaints or grievances from enrollees that are made to plan personnel. In a few report cards, information about utilization review and outcomes was available—that is when the plan evaluates the necessity, use, or appropriateness of a service or procedure.

➢ Information about enrollee or provider complaints made to an external body, such as a state insurance department, Medicare, or a public employer.

➢ Information about external appeals decisions. This generally occurs after an enrollee has exhausted internal health plan complaint processes and the case is reviewed by an independent external organization.
Public information about one of the three types of information above is available in 20 states and through three national resources (Medicare, Consumers' CHECKBOOK's *Federal Employee Guide*, and NAIC).

The most common type of information in this category is complaints to state governmental agencies (usually a Department of Insurance) or to public entities like Medicare, the federal Office of Personnel Management (for FEHBP participants), or a state employer agency. Fourteen states and three national sites had this type of information. Often, the information includes the total number of complaints to the agency, the market share or amount of premium written in the state by the health insurer and some type of complaint ratio—which adjusts the number of complaints by the insurance company's size.

Eight states provide some type of information about internal complaints, grievances or appeals. Generally, the information provided includes the number of complaints/grievances filed and their disposition (number decided in favor of the enrollee, number decided in favor of the plan). In some cases, the disposition in favor of the enrollee is expressed as a “reversal rate”.

Seven states and one national site (Medicare) include information related to independent external appeals. Usually this includes the number of external reviews about a health plan and their disposition—whether decided in favor of the enrollee, in favor of the health plan or partially in favor of both the plan and the enrollee.

Two states in the review (Connecticut and Maine) have information about utilization review (UR) in a health plan. This includes the number of UR requests in the plan, the total number and percentage of UR denials, the total number of denials that were appealed, and the total number and percentage of denials that were reversed on appeal. Connecticut also includes utilization review statistics for mental health, chemical dependency and alcohol and other drug services.

One state in the review (Maine Department of Insurance) has data on all four types of information in this area (though the data in some cases are old) (See Screenshot # 5.) They publicly report:

1) A complaint index based on complaints to the state insurance department
2) The number of complaints received by the health plan and their disposition (including reversal rate)
3) The number of first-time utilization review requests made to the plan, how many were denied, how many were appealed and the number reversed
4) The number of external reviews upheld, overturned or withdrawn

New York State requires that health insurance plans pay claims to doctors and other providers within certain timeframes. In their managed care report card, they include “prompt-pay” complaints—the number of complaints from doctors and other providers about getting paid. They also rank the health plans from 1-12 on their performance in this area. While this information is mostly of interest to doctors, a poor rating in this area may result in higher doctor turnover thereby affecting their patients.
Medicare and NAIC Complaints and Appeals Information

The Medicare Plan Finder also includes information about complaints as part of its overall plan rating. With reference to drug plan rating results, one of the sections of the ratings is: “Drug Plan Member Complaints and Medicare Audit Findings”. The complaint related components of that rating are:

1) Complaints about joining/leaving the drug plan (The number of complaints received by Medicare from every 1,000 people enrolled in the plan)
2) All other complaints about the drug plan (How many other complaints Medicare got about the drug plan)

With reference to Medicare health plans with or without drug coverage, complaints are part of the overall plan rating in a section titled: Health Plan Member Complaints and Appeals. The components of that section include:

1) Complaints about the health plan (How many complaints Medicare receives about the health plan)
2) Timely decisions about appeals (% of plan members who got a timely response when they made a written appeal to the health plan about a decision to refuse payment or coverage)
3) Fairness of health plan's denials to a member's appeal, based on an independent review (How often an independent reviewer agrees with the plan's decision to deny or say not to a member's appeal)

The NAIC CIS database also includes complaint ratios about health plans nationwide. However users can't see this information in a side-by-side comparative view, but rather must enter the name of each company separately and dig through several screens to find the information.

As part of the “Quality Ratings” section of their website, Consumers' CHECKBOOK's Guide to Health Plans for Federal Employees and Annuitants also includes information on disputed claims per 10,000 filed with OPM and the number in which the plan's initial decision was changed or reversed.

Presentation Formats for Complaint and Appeals Information

Much of this type of organizational information is presented in charts with a list of the names of health insurance companies, numbers, percentages, and ratios. In the case of complaints to State Insurance Departments, it is sometimes difficult to tell which companies in a list are HMOs vs. other types of insurance companies. Some websites break out HMOs separately or indicate them in some way. For example, the Maryland format allowed the user to see the plan types along with the corporate sponsor so that under the corporate name UnitedHealthcare, the report had information on: Optimum Choice, MD IPA, Golden Rule and others. In other states, information would only be available at the United HealthCare corporate level.
In some cases, sites allowed the user to search for information from a database. In others the information was in a pdf report format. In only two cases (TX and WI) was there use of a graphic to convey relative performance:

- **WI State employee brochure** presented information about both complaints and grievances in a bar graph format.
- **The Texas Department of Insurance** included information in bar graph format and also included three years of complaint data (See Screenshot # 6).

A few states allowed users to sort complaint performance from high to low—or presented the information in rank order. In many states, the user could see information from previous years.

Ohio had a **two-page brochure** about consumer complaints on health insurance that provided some context for the topic, as well as additional information—including the top 10 reasons for health insurance complaints in 2008 (See Screenshot # 7).

**Medical Loss Ratio Information/ Executive Compensation**

Nine of the managed care report cards reviewed included information about medical-loss ratios (the amount of a premium dollar spent on medical claims vs. administrative costs). This information was available from state insurance departments in Connecticut, Maine, Maryland, Massachusetts, Minnesota, Missouri, Oregon and Rhode Island. The Connecticut Business and Industry Association (a small business exchange in CT) also made the medical loss ratios of its plans available.

In addition, the NAIC Consumer Information Source (CIS) nationwide database includes the medical loss ratio as part of its financial information on plans, but as previously noted, the site is not easy to use.

In most cases, the medical loss ratio is provided in a chart as a percentage number. For example the medical loss ratios for the plans offered by the Connecticut Business and Industry Association ranged from 81.2% to 96%.

With reference to executive compensation, Maine provides information on executive salaries, bonuses, and all other compensation. Certain levels of executive compensation are also available for health plans in Minnesota through their IRS Form 990 non-profit filings.

**Discussion and Recommendations**

Information on complaints, grievances, appeals and other issues has traditionally not been well integrated into existing managed care report cards and this was confirmed by this study. Often this is because the information has been gathered by the State Department of Insurance, rather than the State Department of Health or another more health-oriented organization. This information is important and represents another aspect of performance that should be collected and integrated into the information that is available to consumers about health plans. Of particular interest to
consumers would be information about what happens “inside” the health plan on the disposition of such matters as utilization review or grievances. The importance of this information will be enhanced if there is a robust complaint, grievance and appeal process that is well publicized to enrollees and their families.

Just as efforts have been made to develop “scores” or composites of performance information in the HEDIS and CAHPS areas, the ability to roll several measures on grievances and appeals into one score that is easy for consumers to understand could be investigated. As noted above, the Medicare Plan Finder includes such an approach as it rolls several sub-scores about complaints and other findings into an overall score called “Health Plan Member Complaints and Appeals”.

As with the other types of quality and patient experience information noted above, making this information easily understandable “at-a-glance”, with the opportunity to dig deeper for those who are interested is necessary. And again, including users in the design of this type of information will improve its usefulness and navigability.

RECOMMENDATIONS:

- Integrate information about complaints, grievances, utilization review outcomes and appeals into the performance reports about health plans.

- Ensure that plan information in this area can be interpreted “at-a-glance” with the option to dig deeper to get more information if interested. Include users in the design of the information and test with multiple audiences before implementation of the design.

D. Other Types of Performance and Cost/Payment Information

There were several other types of information that appeared on a small number, or single, managed care report card sites, such as information from an employer-oriented survey called eValue8, information about the costs of hospital, physician and other services provided by the state’s health plans, and a range of other types of information on utilization, broker compensation and other topics.

The eValue8 Tool

Several reviewed report cards provided information derived from the National Business Coalition on Health’s eValue8 tool. This survey tool is primarily used by employers and business coalitions to assess health plans by gathering information in such areas as consumer engagement (how effectively a plan helps members navigate through the health care system, offers choice tools, web-based visits, e-mail and assesses patient experience via CAHPS etc.), provider measurement (how plans use clinical information to differentiate among doctors and hospitals etc.), prescription drug management, prevention and health promotion, chronic disease management and behavioral health—with a particular focus on depression and substance abuse. While primarily for employer use, the following report cards present the eValue8 results for consumers:
The Puget Sound Health Alliance (WA) report card used results from eValue8 to provide information about how area health plans performed across several areas. In the “Working with Members/Consumers” results, for example, bar charts, were used to compare how well the plans did on provider directories, price transparency, performance measures and other types of consumer engagement support.

The Maryland report card provided charts to present information about how well plans performed on the different categories of programs.

Reports using eValue8 are also available from employer groups in Tennessee and Florida.

Cost/Payment Transparency of Hospital and Doctor Services

As noted above, a complete discussion of how information on the cost of care is presented to consumers is beyond the scope of this study. However, in reviewing the IPI database, we identified a few sites that take information provided by the state’s health plans and convert it to consumer information about the average payment for certain health services or conditions.

In Oregon, the nine largest health plans report information to the state Department of Consumer and Business Services about hospital payments in the state for selected procedures. For example, in that state, the average payment for a vaginal delivery of minor/moderate severity ranged from $2,969 to $6,076 at three Oregon hospitals. The site notes limitations, however, in that Medicare, Medicaid and self-pay patients are excluded and extremely high and low payments are also not included.

The New Hampshire Insurance Dept. (http://www.nhhealthcost.org/) hosts a site that provides a cost estimate of a service in a hospital or surgery center or provided by a physician or other health care professional. Users must first indicate whether they are insured or uninsured and then choose the type of service they are interested in: preventive, emergency visits, radiology, surgical procedures or maternity. For insured patients, the user must enter information about their zip code and what insurance carrier, plan, deductible and co-insurance they have. The results then give an estimate of what the consumer will pay at various providers, what the insurance company will pay and the combined payment. It then gives a rating of the precision of the estimate (how accurate the estimate is based on statistical analysis and historical experience) ranging from very low precision to higher precision and the typical patient complexity of the procedure being evaluated (how healthy or sick patients are).

Minnesota Community Measurement, a non-profit collaborative, allows users to view information about the range of payments made for physician services such as lab tests (pap smear, strep test, urine culture), medical services (childhood immunizations) or obstetrical services (vaginal delivery or C-section). The information came from four large health plans in Minnesota. The results include the average medical group cost of the procedure, as well as the highest, median and lowest cost.
Other Types of Performance Information

Other types of information included that appeared on only one or two sites included:

- **Frequency of Procedures or Hospitalizations:** The New Jersey HMO Performance Report Card included information on the frequency of two types of procedures by plan that may be over-used: 1) Tonsillectomy and 2) Cardiac Catheterization. The information included the age and sex of those receiving the two procedures, the number of procedures and number of procedures per 1,000 member years. This information is likely provided to make the public aware of expenditures for services that are costly but may not be necessary. (See page 13)

- **The Pennsylvania Health Care Cost Containment Council** included information on the rates of hospitalizations for conditions which could have been prevented by effective primary care. These included hospitalizations for pediatric ear, nose and throat infections, high blood pressure, and kidney or urinary tract infections. Here again, this information documents areas of potential savings that would not compromise health care quality. (See page 15-17)

- **Compensation for independent agents/brokers:** The Medicare Plan Finder includes a link to a file containing the amounts companies pay to independent agents/brokers to sell their Medicare drug and health plans. The file is a large excel spread sheet that lists plans by state, whether they use independent agents and the range of compensation the independent agent may receive from that company.

- **Physician Termination:** The Massachusetts Department of Health and Human Services provides information on the number of voluntary and involuntary physician terminations in the state's health plans. The information includes the percentage of physicians who voluntarily and involuntarily terminate their contract and the top three reasons for that termination (including such issues as relocation, retirement, but also quality of care issues and failure to meet re-credentialing requirements).

- **Consumer's Role in Rate Review:** The Oregon Insurance Division allows citizens to view and offer comment on health insurance rate reviews. Information in a database includes the percentage change requested, the change approved, the number of members covered, and the effective date of the increase.

- **Patient Safety Initiatives:** As part of the information available about each plan through the federal FEHBP program, there is information about the plan's patient safety initiatives such as programs to deal with drug-to-drug interactions, provider recognition, quality improvement work plans and other activities.

**Discussion and Recommendations**

There are a variety of measures that are available in some states that look at other aspects of health plan performance, such as utilization, compensation, physician termination, or patient safety. There may be good reasons to include these measures in a state's health insurance exchange measurement and reporting system. States should be allowed flexibility to include measures that stakeholders—
and in particular a state's consumer groups—feel are important, though it might be preferable for this type of information to be available in a separate comparative format from the health insurance exchange or directly from the health plan. When these additional types of information are provided, it will be important for the data to be comparable across plans so that consumers can make valid comparisons. Therefore, the state/exchange must specify standard data collection criteria.

Efforts to include information about the health care costs of particular services and providers, such as that included in certain cost estimators, should be paired with quality information wherever possible, given that many consumers don't understand that higher cost does not automatically mean better quality. In addition, as recommended in the Quality Alliance Steering Committee's *Recommendations for Reporting Cost and Price Information to Consumers*, cost information should be actionable, easy-to-understand, easily available, timely, credible and personalized and customized. The limitations of cost-estimators must also be noted—particularly if they don't include data from all types of insurance. Their usefulness in giving consumers a “ball-park” estimate of the range of costs for procedures and services is limited by their inability to give a specific cost estimate based on the consumer's actual health coverage.

**RECOMMENDATIONS**

Allow flexibility to states to include additional performance measures that are of interest—particularly to consumer groups.

Include quality information with cost information wherever possible. Utilize other recommendations on reporting cost and price from the Quality Alliance Steering Committee.

**VI. EDUCATION AND DECISION SUPPORT**

Managed care report cards included a variety of approaches to help users understand their content, make decisions about health insurance and get more information if needed. “How-to” information, worksheets, glossaries, links to other resources and interactive tools to help with plan selection were all available on some websites. A small number of sites also used video technology to help explain information and were available in languages other than English.

**A. Educational Information**

About one-quarter of the managed care plans reviewed had information for users about how to be an informed or engaged consumer. For example, several sites had content about “How to choose a health plan” or “managed care plan” that included steps, guidelines or questions. Examples include:

- The California Office of the Patient Advocate site provided information about what good or poor HMO quality would look like as well as information about choosing and using physicians in HMOs, costs, prescription drugs and rules and restrictions.

- NCQA has a section on “How to Choose a Health Plan” that includes a few simple guidelines to find quality health care.
The Pennsylvania Health Care Cost Containment Council has a “How to Use this Report” section that includes questions to ask HMO representatives in several areas including “Helping to keep Members Healthy,” “Preventing Hospitalization thru Primary Care”, and “Managing Ongoing Illnesses” (see pages 4-5).

Worksheets that help users compare health plan alternatives were another feature of some sites including:

- The Connecticut Insurance Department: (see page 4)
- The Colorado Business Group on Health (see page 16)
- The Texas Office of Insurance Council includes section on “What to Consider when Choosing an HMO” that includes questions and a worksheet (see page 3)

Some of the report cards include general information on being an engaged and informed consumer—including information about a consumer's rights in a managed care plan. For example:

- The Maryland Health Care Commission includes tips on what it means to be an engaged health care consumer and why this is important (see page 3)
- The Louisiana Department of Health & Hospitals includes a “Get Better Care” topic that suggests getting involved, staying healthy and being informed.
- CalPERS includes a section titled “Be Well Informed” that includes information and links on obtaining the best health care possible, finding quality health care and other topics.
- The Texas Office of Public Insurance Counsel includes good information on an enrollee's legal rights in an HMO.

A different type of educational material is provided by the NAIC through their Insure U website. This site includes a range of consumer-oriented information for people in different life situations including young singles, young families, established families, seniors, domestic partners, single parents, military, and raising grandchildren. The site provides information about auto, home and life insurance in addition to health insurance. State insurance departments incorporate the Insure U content into their own websites.

About 20% (14) of the sites had glossaries or “definition of terms” sections that helped users understand unfamiliar words and concepts—including a glossary that is available on the DHHS Healthcare website. Examples of words that are defined in various glossaries include “allowed charge”, “coinsurance”, “copayment”, “deductible”, “drug formulary” and “participating provider”. The Wisconsin Managed Care Report also has a list of acronyms including CMS, HMO, NCQA and POS.

Finally, many of the sites include links to other resources that could be helpful to a user including some that are not specifically related to health insurance, such as:
- State agencies such as Attorney General's office, children/youth and families, elder affairs, disability agencies, health departments, insurance departments, Medicaid, patient advocates, SHIP programs, and social services
- Federal agencies such as AHRQ, the Department of Labor, Medicare, and Social Security
- Other national and local non-profits providing assistance such as NAIC, NCQA, health plan associations, The Joint Commission, National Quality Forum, and URAC
- More general health sites such as Medline Plus and Healthfinder, CDC or disease specific groups such as the American Heart Association or the American Diabetes Association

One reference seen on several sites was this AHRQ publication:

**Questions and Answers about Health Insurance: A Consumer Guide**

**B. Health Plan Selection Tools**

Given the complexity of reviewing and understanding information about health plan choices, some sites include an online tool to make the process easier. Health plan selection tools take users through a series of steps to help narrow their plan choices. Generally, this involves having the user enter information about his needs, interests or values so that the tool can filter the information to provide only that which reflects these specified preferences.

Only a few of the reviewed report cards included a plan chooser tool—in part because the tools are generally designed to include actual benefit and cost information. As previously noted, most of the managed care report cards reviewed in this report provided more general information about plan quality rather than specific information on benefit and cost data.

The following sites did have plan choosers or decision support tools which are briefly discussed below:

**Pacific Business Group on Health**

**Cal-PERS** offers an online Health Plan Chooser that was developed by the Pacific Business Group on Health (PBGH).

The chooser is a five-step process that provides key information about each health plan. At each step, the user can rate how well a plan fits her needs. At the end, a “Results Summary” highlights the plans rated as the best fit in each category.

After entering or choosing information such as demographic data (type of coverage, employer monthly premium contribution, zip code etc.), whether/how often you take medications, your general health status (no health problems, moderate etc.), and your interest in certain plan features and services (stop smoking programs, acupuncture, money saving), the chooser then provides an estimate of out-of-pocket costs for each plan. Based on that information you can “rate” the fitness of a plan from a “good” fit, to “so-so” to “poor”. The user has the option of eliminating plans that are not determined to be a good fit.
The second step of the Chooser allows the user to search each plan's doctor directory to see if a desired doctor is in their network. Again, the user can rate the plan in terms of fitness and remove it from consideration.

The third step of the Chooser compares plans on member CAHPS information and clinical quality (based on HEDIS data) and again, the user can rate the fitness of the plan. Fourth, users identify whether plans have particular desired features, such as stop smoking programs or programs for diabetes or money-saving programs. Again, they can rate the fitness of the plan.

Finally, users can view the out-of-pocket costs for various services that had earlier been indicated as being important. For example prescription drug costs or acupuncture visits. The final information gives the user's ratings of the plans across the categories of Costs, Doctors, Plan Performance Ratings, Features and Services.

Rather than going thru each screen sequentially, the user can also choose to see all of the information at once and remove plans that are not of interest.

A study by PBGH “Helping Employees Choose a Health Plan” looked at how 190,000 visitors across eight employers used the Health Plan Chooser during the fall of 2009. Use of the tool varied from 3% of employees to 71% (typically 15-20% of employees use the tool). The study found that the vast majority of people report that their share of costs, coverage levels and access to doctors are top concerns as they choose a health plan.

The research concluded with best practices regarding decision support to evaluate health plans. These included:

- The ability to compare all plan choices in a single view.
- A simple calculator to estimate and compare out-of-pocket costs.
- An easy way to find doctors in each plan.
- A way to tailor the comparison to highlight plan services of interest such as weight loss services.
- Concise information focused on key aspects of choice such as premium costs, cost at the time of service, and services covered.

**Medicare**

Medicare also includes a “Plan Finder” feature on its website. There are two options—a general search based on zip code and a more personalized search based on detailed information such as one's Medicare number and date of birth.

With regard to the general search, after putting in one's zip code, the user is prompted through a series of questions that include type of Medicare coverage, whether she gets “extra help” (i.e., subsidy), the drugs she takes (need to know dosage and frequency), and the pharmacy she prefers. Users then get results across the four types of plans that are available—Original Medicare, Medicare health plans without drug coverage, Medicare health plans with drug coverage and just prescription drug plans. This top-level search result includes the “average” overall rating of three of
the plan types (there is no overall plan rating for Original Medicare). Going one layer down results in information about each plan's costs, whether your drug is on the formulary and an overall star rating of the plan.

In addition, the plan results also include an estimate of out-of-pocket costs for each plan—breaking down the estimate by monthly and annual premium costs and estimated costs for inpatient care, outpatient prescription drug, dental services and all other services. As further explained in the “How We Calculate the Out-of-Pocket Costs Data” section, this information is based on self-reported data from the Medicare Current Beneficiary Survey matched to individual claims history.

**WI Health Insurance Exchange Prototype**

The prototype that is available to review by the WI Health Insurance Exchange first involves a user identifying which of five family scenarios he most identifies with (a young single woman, a divorced woman, an older married couple, a family or an older single man). Each of these scenarios also includes differing monthly and annual incomes. Once the scenario is picked, the user is told they will be taken through a three-step process that will take approximately 15 minutes and will require entering personal information such as a Social Security number. After creating an account with the site, a series of questions about income are posed that help determine whether the user is eligible for any subsidy. Users are then asked about their health behaviors and conditions and whether they have any preferred doctors or hospitals and, if so, to enter their names.

The user is then asked to rank their health plan preferences from most important to least important. These include:

- High overall quality
- High quality for your health conditions
- Your doctors are included
- Your hospitals and clinics are included
- Low monthly premium
- Low out-of-pocket expenses
- Good customer service

Results about health plans are then presented in rank order based on the user’s input. The information provided for each plan option includes the monthly premium, estimated out-of-pocket expense, overall quality of care, quality for the identified health conditions, customer service and whether the identified doctor, clinic or hospital are available. The quality and customer service columns use grades “A” - “C” to indicate results. It appears that users will be able to filter results based on premium costs, quality or whether the plans include the preferred doctor. Up to three plans can be compared. However, it's not clear that the underlying scores that led to the ranking of “A” to “C” are transparent.

**Healthcare.gov (DHHS)**

The Department of Health and Human Services (DHHS) website also includes some higher level decision support that allows one to search for health insurance options by state, demographic
(family/children, senior, individual with medical condition), age, and other situational factors (losing health insurance, breast or cervical cancer, Veteran etc.). The results include the range of options that might be available in your state such as health insurance through work, high risk pools, or Medicaid. Links are then provided to more details about these options—often from other state websites.

In some cases, you can also get more customized information. For example, under the option “health insurance plans for individuals and families”, after entering some demographic information, the user gets a list of private insurance plans with information on out-of-pocket limits, annual deductibles, monthly premium estimates, what percentage of applicants received a surcharge and how many people have been denied coverage. They can then dig deeper for details of each plan, compare up to three plans and sort information based on desired factors. In comparing information about Maryland plans on the federal vs. MD Insurance Administration website, it appears that information on Healthcare.gov is more extensive, richer and easier to use.

**FEHBP PlanSmartChoice**

A review of the video about the FEHBP’s Plan Smartchoice tool (one has to register to use the actual tool with specific information about being a federal employee) indicates that it includes a medical cost calculator, a comparison module that shows how medical benefits vary by plan and a savings account estimator. A preference module is also available that involves ranking how important certain plan features are such as monthly costs. The tool then presents you with a series of “trade-off” questions that force you to choose between two hypothetical alternatives. Based on this information a list of medical plans appears in rank order based on how well the plan meets your personal profile. The tool was designed by Asparity Decision Solutions in Durham, NC and is available [here](#). According to the Asparity website, approximately 85,000 federal employees used the tool during the 2011 open season which ended December 13, 2010, with more than 8,000 using the site on the last day of enrollment.

**Consumers’ CHECKBOOK’s Guide**

*Guide to Health Plans for Federal Employees and Annuitants*, produced by the nonprofit Consumers’ CHECKBOOK organization, has been published for 32 years, and is supported by payments by individual users in print and online and by many Federal agencies purchasing access for their employees. The user enters zip code, employment information, retirement and Medicare status, family size, age category, whether premiums will be paid pre-tax, and whether participating in a Flexible spending account. The next click takes the user to a Summary table listing all available plans by type (HMO, Consumer Directed, etc.) in rank order based on premiums plus estimated out-of-pocket costs. The out-of-pocket cost figures are based on actuarial estimates for persons of similar age and family size using data from AHRQ’s Medical Expenditure Panel Survey and other sources.

CHECKBOOK reports that its user surveys and tracking show that overall cost comparison is the top priority for most users. The Summary table also includes for each plan an estimate of the cost “limit to you” and the overall rating on the health plan CAHPS survey. The user can drill down through various other tables for information on the risk of very high costs under each plan, coverage
and cost-sharing provisions, special coverage features (like hearing aids, vision care, acupuncture, infertility treatment, and a detailed evaluation of dental benefits), plan flexibility (effect of using non-preferred providers, different formulary levels), and quality measures (results on various CAHPS survey composites and individual questions, accreditation, and rates of disputed claims). CHECKBOOK’s *Guide* also has extensive advice on how to choose a plan including such considerations as tax effects and availability of coverage through a spouse. The 2011 plan *Guide* is accessible at GuideToHealthPlans.org logging in with Username “toolreview” and Password “review”.

**C. Language and Use of Videos**

Finally, several sites had health plan report card information available in other languages or used videos and stories to convey information. These included:

- Sites in Connecticut, Maryland, Texas and the Medicare Plan Finder were all available in Spanish. The site in California was available in both Spanish and Chinese in addition to English.

- Sites that used videos to provide information such as the Florida Health Finder and Massachusetts Health Connector sites. The Massachusetts Health Connector site also includes stories from a variety of Massachusetts residents about their experiences looking for health insurance.

**Discussion and Recommendations**

Choosing and using health insurance is one of the more complicated tasks Americans face. There are many concepts and words that are unique to the process and are not easily understood such as deductible, co-insurance, co-pay, pre-authorization, in-network and out-of-pocket-maximum. These words and concepts are important as they affect how much one has to pay for care, who one gets to see for care and when care can be received. However, given their complexity, many people don’t focus on health insurance words and concepts until they need to, at minimum, when they enroll or re-enroll in a plan or when they have to use the plan.

Given this complexity, designers of health insurance exchanges should assume that the population that will be using their website knows nothing (or very little) about health insurance and health insurance concepts and health insurance choices. Designers should assume a low level of health literacy and numeracy amongst potential users. Assuming no knowledge and limited health literacy should result in website language that explains concepts using simple words, limits the use of acronyms, repeats information often, and makes explicit ideas that seem obvious to those who work in the field.

From a design and navigation standpoint, health insurance exchange sponsors should bear in mind that website users can enter the site at any point and may not use it in the linear way one would read printed material. Minimizing the number of clicks needed to get information will be important. For example, using “roll-over” or “hover” text to define unfamiliar words instead of, or in addition to a traditional glossary. Exchange website designers should utilize strategies from such resources as
the federal government's **Usability Guide** and the CMS health literacy **Toolkit for Making Written Material Clear and Effective** in their work.

The extent to which tools and resources can easily help individuals and families make decisions should be tested and implemented. These might include worksheets, plan selection tools, calculators and other resources. Multiple options might be available to match different learning styles—for example some users might want to go through a step-by-step process, while others prefer short-cuts that allow them to get to the results quickly. Instructions and information about how to use these tools should be as simple and intuitive as possible and should be tested with different types of potential users to maximize usefulness.

Given the growing cultural diversity of the American population, efforts should be made to ensure that information provided through health exchanges about health plan options is culturally appropriate (i.e., respectful of and responsive to the values, beliefs, and customs of different racial, ethnic, religious or other groups) and, when appropriate, available in languages other than English.

As the Internet evolves, utilizing new media such as social media, blogs, videos and other outreach mechanisms might be considered—particularly to reach audiences that are most familiar with these types of tools. In addition, consideration will also need to be given to how to provide information for people who do not have access to the Internet.

**RECOMMENDATIONS**

- Assume no audience knowledge of health insurance and low health literacy levels in the design and writing of materials about health insurance options in order to maximize accessibility and understanding for all users/Utilize resources such as federal government's **Usability Guide** and the CMS health literacy **Toolkit for Making Written Material Clear and Effective**.

- Explore multiple decision support approaches in order to maximize the opportunity to match a tool with a user's learning style including the use of short-cuts and other techniques to facilitate navigation.

- Ensure that information about health plan options is culturally appropriate (i.e. respectful of and responsive to the values, beliefs, and customs of different racial, ethnic, religious or other groups) and available in languages other than English, as appropriate.

- Include new media options to reach certain audiences, but also have a process to help users who do not have access to the Internet.

- Test all decision aid tools and resources to ensure that they are understandable and useful to individuals and families.
VII. INTEGRATION OF INFORMATION ABOUT PHYSICIANS, HOSPITALS AND
OTHER HEALTH PROVIDERS

In addition to performance information about health plans found on the Internet, there is a fair
amount of online performance information available about hospitals and some, though growing,
information about doctors and other health professionals. For example, one can access disease-
specific information about how well a hospital or doctor does in treating patients with certain
conditions, such as diabetes or heart care. You can also learn about mortality rates for hospitals or
how many times a doctor performs a certain type of procedure. These hospital and physician report
cards are sponsored by a variety of organizations including states, non-profit organizations, the
media, and the federal government.

As consumers think about their health plan options during open enrollment, there is an opportunity
to consider the quality of what's “inside” the health plan—the doctors, hospitals and other health
providers that actually take care of patients. Often, whether a plan offers one's current doctors and
other preferred facilities is a key factor affecting an individual's health plan choice according to a
variety of research findings, but other factors are important as well.

This review of publicly available managed care report cards found little thought had been given to
how to integrate information about the quality of health professionals and organizations into health
plan report cards. Over half the report cards reviewed didn't include any reference to where to get
information about physician's or other health professionals associated with the plan. The 16 report
cards that did mention providers, simply linked to the home page of the health plan website where
the user would have to find a provider directory themselves. Six of the report cards provided a deep
link to the health plan's provider directory.

In some cases, where the managed care report card is available through a portal, or a site that offers
a range of types of health information, other types of report cards are available if the user comes to
the site through the portal's home page. For example, the California, Colorado, Louisiana and
Florida websites offer a portal and access to comparative information about medical groups,
hospitals, nursing homes or other providers. However, generally the information is not well
integrated in that it does not link providers to plans. The federal website Healthcare.gov also
includes a prominent category titled “Compare Care Quality” on its website. It links to Hospital
Compare, Nursing Home Compare, Home Health Compare and Dialysis Facility Compare, though
it doesn't include any information on health plan quality.

It must be noted that it was beyond the scope of this review to evaluate the websites of plans
themselves where information about the quality of individual providers may reside. For example,
many health plans do include some information about the quality or background of the health
professionals and facilities associated with their plan. However, these websites are usually only
available to those enrolled in the plan. In any event, consumers need complete information to make
decisions that best suit their needs. This suggests that the exchanges will have to address the
integration of information from many sources to meet this objective.
Discussion and Recommendations

The process of reviewing plan options in the context of an initial or ongoing enrollment through a state health insurance exchange offers a “teachable moment” for individuals to consider information and choices about the quality and efficiency of providers offered by the plan. It is already well known that people's decisions about health plans are often driven by whether their preferred doctors are part of the plan. Indeed, one way to make that process simpler and easier for users is to have one database of physicians that links them to all of the plans that they (physicians) belong to. Users would then have to enter their name into one search engine to have that information brought to them, rather than having to click through to multiple provider directories. This type of functionality is included in the Wisconsin Health Insurance Exchange prototype, but no decision has been made by the exchange as to whether and how it will be included in the final version. The information would need to be continually updated and accurate which could be challenging for the exchanges. Ideally, specific information about the quality of care provided by individual physicians would be linked to other types of provider-specific information.

A major challenge in this area is the absence of standardized information on provider performance. Plans may use different methods to evaluate physicians and hospitals that result in different performance scores. Linking consumers to plan-specific information could result in confusion given different quality or patient satisfaction scores for the same physician or hospital. At minimum health insurance exchanges could explain why this might happen given the different methods that health plans use. It could also spur community, regional or state conversations about standardizing physician measurement across health plans in order to minimize consumer confusion and physician burden. In the meantime, links to or other state and national physician and hospital report card websites such as those on the Informed Patient Institute's website could be considered.

RECOMMENDATIONS

- Capitalize on the “teachable moment” of health plan enrollment or re-enrollment to encourage consideration of the quality and efficiency of the health providers “inside” a health plan.

- Ensure the accuracy of the information provided about physicians and hospitals—particularly with regard to their continued affiliation with the plan.

- Make access to information about the availability and quality of physicians and other health providers easy to find and use and decrease the chance for confusion due to multiple and differing scores for the same health providers.

- Move to align information across payers by standardizing data collection and reporting approaches to ensure that the information can be reliably used for comparisons.
VIII. CONCLUSION

As state health insurance exchanges consider how to provide information to consumers, they can draw on the experience of states and non-profits that have been publishing report cards for some time. This review of 70 managed care report cards revealed a range of types of information available for consumers about the performance of managed care plans. Information about the clinical quality of care and patient's experience of care in health plans has long been available utilizing HEDIS and CAHPS measures. Other types of information—such as that on complaints and appeals about health plans—is also available, although it is not always well integrated into report cards. The important issue of how best to convey information about the cost of care was only briefly touched on here but will be a central issue addressed by exchanges.

In addition to the content of the reports, the usability of the health insurance exchange sites will be equally important. Given the complexity of health insurance decisions, techniques and tools that help users quickly understand the information and narrow down choices that are most relevant to their situation will be an important component of these websites. Consumer-testing materials and tools will help ensure that they are understandable and usable.

Designing the health insurance exchange website with the end-user consumer in mind will be the most important factor in the success of the insurance-shopping experience envisioned in the new law. Ironically, the complexity of making the information and selection process simple for consumers may entail more work for health insurance exchanges in terms of testing, writing in plain English, designing evaluable formats, and providing contextual information. There will certainly also be political challenges and tradeoffs involved in decisions to offer fewer plans rather than more, to make a wide range of performance information transparent or to design sites that quickly convey which plans have better performance. The extent to which exchanges accept these challenges to design consumer-friendly sites will determine how easy it will be for residents to get and keep health insurance.
IX. COMPILED LIST OF RECOMMENDATIONS

NUMBER OF HEALTH PLAN CHOICES

Consider the burden of consumer decision making in deciding how many health plans to offer. In general—fewer, rather than more, choices will assist in decision making.

Include tools and resources to assist consumers in narrowing choices.

Minimize consumer confusion by considering how to standardize and “name” health plan benefit package options.

HEALTH PLAN PERFORMANCE INFORMATION

Recommendations about Insurance Exchange Report Card Content

Include the following types of comparative information in online health insurance exchange report cards:

- Information on patient experience of care from CAHPS
- Information on quality of care based on HEDIS ideally using a composite measure(s) that aggregate(s) performance across a few categories (with the option to drill down for more information if interested)
- Information that reflects other aspects of enrollee plan experience preferably using a composite measure that includes measures such as utilization review outcomes, claims denials, complaints to the plan, external appeals outcomes, complaints to the health insurance exchange and disenrollment (similar to Medicare's Health Plan Member Complaints and Appeals Findings in their Plan Ratings) – again with the option to drill down for more specific information if interested.

Make the following types of information publicly available—ideally in a comparative format from the health insurance exchange or from the plan itself. If from the health insurance exchange, include a link in the exchange report card to let users know that it is available

- Medical loss ratios
- Financial information about the plan
- Information on premium rate justifications
- Accreditation status
- Other types of information of interest to consumers such as physician turnover, descriptions of plan patient safety activities etc.

Feature plan quality performance as prominently as other aspects of plan information, such as costs.

Include quality information along with cost information wherever possible/Utilize other recommendations on reporting cost and price from the Quality Alliance Steering Committee.
Allow flexibility to states to include additional performance measures that are of interest—particularly to consumer groups.

**Recommendations about Presentation and Navigation**

Ensure that plan quality information can be interpreted “at-a-glance” with the option for users to dig deeper in areas of interest if desired. Use an organizing framework to categorize more detailed information.

Consider using “stretch” benchmarks or other approaches when creating plan quality scores that will both motivate improvement and show variation among plans.

Measure plan performance at the level closest to that reflecting the actual plan that consumers enroll in that is both feasible and that captures differences amongst plan types.

Include users in the design of health insurance exchange websites and test the design to ensure its usefulness and navigability to consumers.

**EDUCATION AND DECISION SUPPORT**

Assume no audience knowledge of health insurance and low health literacy levels in the design and writing of materials about health insurance options in order to maximize accessibility and understanding for all users/Utilize resources such as the federal government's Usability Guide and the CMS health literacy Toolkit for Making Written Material Clear and Effective.

Explore multiple decision support approaches in order to maximize the opportunity to match a tool with a user's learning style including the use of short-cuts and other techniques to facilitate navigation.

Ensure that information about health plan options is culturally appropriate (respectful of and responsive to the values, beliefs, and customs of different racial, ethnic, religious or other groups) and available in languages other than English, as appropriate.

Include new media options to reach certain audiences, but also have a process to help users who do not have access to the Internet.

Test all decision aid tools and resources to ensure that they are understandable and useful to individuals and families.

**INTEGRATION OF INFORMATION ABOUT PHYSICIANS, HOSPITALS AND OTHER HEALTH PROVIDERS**

Capitalize on the “teachable moment” of health plan enrollment or re-enrollment to encourage consideration of the quality and efficiency of the health providers “inside” a health plan.
Ensure the accuracy of the information provided about physicians and hospitals—particularly with regard to their continued affiliation with the plan.

Make access to information about the availability and quality of physicians and other health providers easy to find and use and decrease the chance for confusion due to multiple and differing scores for the same health providers.

Move to align information across payers by standardizing data collection and reporting approaches to ensure that the information can be reliably used for comparisons.
## Screenshot #1: NCQA Health Plan Report Card

**Accreditation Ratings**

NCQA Accreditation ratings summarize overall plan performance on a number of standards and measures. Plans with a higher NCQA Accreditation status can be generally expected to provide better care and service than plans with lower accreditation statuses. Plans with PPO Accreditation can receive a maximum of 5 stars in each category because **REDCARDS** results were not scored for this accreditation program; plans with MCO or Health Plan Accreditation (HMO, POS or PPO) can receive a maximum of 4 stars in each category because **REDCARDS** results are scored for these programs. View more information about Accreditation ratings.

Note: NCQA retired the Quality Plus Distinction listing for surveys effective July 1, 2010. NCQA Health Plan Accreditation incorporated the standards previously covered by the NCQA Quality Plus Distinction program starting with the 2008 Standards and Guidelines. Physician and Hospital Quality is now a certification program. Click here to view databases.

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Plan Type</th>
<th>Accreditation Type</th>
<th>Access and Service</th>
<th>Qualified Providers</th>
<th>Staying Healthy</th>
<th>Getting Better</th>
<th>Living with Illness</th>
<th>Overall Accreditation Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna Health Inc. (Pennsylvania - Harrisburg)</td>
<td>Commercial</td>
<td>HMOPOS Combined</td>
<td>★★★★★</td>
<td>★★★★★</td>
<td>★★★★★</td>
<td>★★★★★</td>
<td>★★★★★</td>
<td>Commandable</td>
</tr>
<tr>
<td>CareFirst BlueChoice</td>
<td>Commercial</td>
<td>HMOPOS Combined</td>
<td>★★★★★</td>
<td>★★★★★</td>
<td>★★★★★</td>
<td>★★★★★</td>
<td>★★★★★</td>
<td>Commandable</td>
</tr>
<tr>
<td>COA Health Care HMO, Inc.</td>
<td>Commercial</td>
<td>HMOPOS Combined</td>
<td>★★★★★</td>
<td>★★★★★</td>
<td>★★★★★</td>
<td>★★★★★</td>
<td>★★★★★</td>
<td>Excellent</td>
</tr>
</tbody>
</table>

Updated as of 3/31/2011

Page 1 of 1 Displayed
Screenshot #3 – Medicare Plan Finder (next 2 pages as well)
Screenshot #3 (Cont.) Medicare Plan Finder
Screenshot #3 (Cont.) Medicare Plan Finder

<table>
<thead>
<tr>
<th>Summary Rating of Health Plan Quality (7)</th>
<th>2.5 out of 5 stars</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stayin Healthy: Screenings, Tests and Vaccines (7)</td>
<td>2 out of 5 stars</td>
</tr>
<tr>
<td>Breast Cancer Screening (7)</td>
<td>2 out of 5 stars</td>
</tr>
<tr>
<td>Colorectal Cancer Screening (7)</td>
<td>2 out of 5 stars</td>
</tr>
<tr>
<td>Cholesterol Screening for Patients with Heart Disease (7)</td>
<td>2 out of 5 stars</td>
</tr>
<tr>
<td>Cholesterol Screening for Patients with Diabetes (7)</td>
<td>2 out of 5 stars</td>
</tr>
<tr>
<td>Glaucoma Testing (7)</td>
<td>2 out of 5 stars</td>
</tr>
<tr>
<td>Monitoring of Patients Taking Long-term Medications (7)</td>
<td>2 out of 5 stars</td>
</tr>
<tr>
<td>Annual Flu Vaccine (7)</td>
<td>Not enough data available to calculate measure</td>
</tr>
<tr>
<td>View how these plans compare to Original Medicare</td>
<td>2 out of 5 stars</td>
</tr>
<tr>
<td>Pneumonia Vaccine (7)</td>
<td>Not enough data available to calculate measure</td>
</tr>
<tr>
<td>View how these plans compare to Original Medicare</td>
<td>2 out of 5 stars</td>
</tr>
<tr>
<td>Improving or Maintaining Physical Health (7)</td>
<td>Not enough data available to calculate measure</td>
</tr>
<tr>
<td>Improving or Maintaining Mental Health (7)</td>
<td>Not enough data available to calculate measure</td>
</tr>
<tr>
<td>Osteoporosis Testing (7)</td>
<td>2 out of 5 stars</td>
</tr>
<tr>
<td>Monitoring Physical Activity (7)</td>
<td>2 out of 5 stars</td>
</tr>
<tr>
<td>At Least One Primary Care Doctor Visit in the Last Year (7)</td>
<td>2 out of 5 stars</td>
</tr>
<tr>
<td>Managing Chronic (Long Term) Conditions (7)</td>
<td>2 out of 5 stars</td>
</tr>
<tr>
<td>Osteoporosis Management (7)</td>
<td>2 out of 5 stars</td>
</tr>
<tr>
<td>Eye exam to check for damage from diabetes (7)</td>
<td>2 out of 5 stars</td>
</tr>
<tr>
<td>Kidney function testing for members with diabetes (7)</td>
<td>2 out of 5 stars</td>
</tr>
<tr>
<td>Plan Members with Diabetes whose blood sugar is under control (7)</td>
<td>2 out of 5 stars</td>
</tr>
<tr>
<td>Plan Members with Diabetes whose Cholesterol is Under Control (7)</td>
<td>2 out of 5 stars</td>
</tr>
<tr>
<td>Controlling Blood Pressure (7)</td>
<td>2 out of 5 stars</td>
</tr>
</tbody>
</table>
## Quality Composite Rating Chart

Understanding the scores for the health plans:

- ★★★★☆ 4 stars - Well above the average of all health plans (by more than one standard deviation)*
- ★★★☆☆ 3 stars - Above the average of all health plans (by less than one standard deviation)*
- ★★★☆☆ 2 stars - Below the average of all health plans (by less than one standard deviation)*
- ★★★☆☆ 1 star - Well below the average of all health plans (by more than one standard deviation)*

Please see previous page for descriptions of the Quality Composite Ratings.

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Overall Quality</th>
<th>Wellness and Prevention</th>
<th>Behavioral and Mental Health</th>
<th>Disease Management</th>
<th>Consumer Satisfaction and Experiences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anthem BCBS</td>
<td>★</td>
<td>★</td>
<td>★★</td>
<td>★★</td>
<td>★</td>
</tr>
<tr>
<td>Arise Health Plan</td>
<td>★★★☆☆</td>
<td>★</td>
<td>★★</td>
<td>★★</td>
<td>★</td>
</tr>
<tr>
<td>Dean Health Plan</td>
<td>★★</td>
<td>★★</td>
<td>★★</td>
<td>★★</td>
<td>★</td>
</tr>
<tr>
<td>GHC of Eau Claire</td>
<td>★★★★☆</td>
<td>★★</td>
<td>★★</td>
<td>★★</td>
<td>★</td>
</tr>
<tr>
<td>GHC of SCW</td>
<td>★★★★☆</td>
<td>★★</td>
<td>★★</td>
<td>★★</td>
<td>★</td>
</tr>
<tr>
<td>Gundersen Lutheran</td>
<td>★★★☆☆</td>
<td>★★</td>
<td>★★</td>
<td>★★</td>
<td>★</td>
</tr>
<tr>
<td>HealthPartners</td>
<td>Not Available</td>
<td>Not Available</td>
<td>Not Available</td>
<td>Not Available</td>
<td>Not Available</td>
</tr>
<tr>
<td>Health Tradition</td>
<td>★★★☆☆</td>
<td>★★</td>
<td>★★</td>
<td>★★</td>
<td>★</td>
</tr>
<tr>
<td>Humana Eastern</td>
<td>★</td>
<td>★★</td>
<td>★★</td>
<td>★★</td>
<td>★</td>
</tr>
<tr>
<td>Humana Western</td>
<td>★</td>
<td>★★</td>
<td>★★</td>
<td>★★</td>
<td>★</td>
</tr>
<tr>
<td>Medical Associates</td>
<td>★★★★☆</td>
<td>★★</td>
<td>★★</td>
<td>★★</td>
<td>★</td>
</tr>
</tbody>
</table>
### Utilization Review Requests, Decisions, and Appeals

Four performance areas are presented in this Interactive Guide. Select from the toolbar above to view each of the comparative charts. Below each chart is a description on how to read and understand the results.

<table>
<thead>
<tr>
<th>Insurer/HMO</th>
<th>Number of</th>
<th>Number of Decisions</th>
<th>Number of Decisions</th>
<th>Number of First-Time UR Denials that were Reversed by the Insurer/HMO when the Covered Person Appealed - Reversal Rate is also shown (see explanation below)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>First-Time UR Requests Made to the Insurer/HMO</td>
<td>Deny First Time Requests for Services for the Covered Person</td>
<td>Deny First-Time Requests for Services that were Appealed by the Covered Person</td>
<td>(see explanation below)</td>
</tr>
<tr>
<td>Aetna Health, Inc.</td>
<td>4,029</td>
<td>242</td>
<td>65</td>
<td>25 40%</td>
</tr>
<tr>
<td>Anthem Health Plans of Maine</td>
<td>14,740</td>
<td>1,890</td>
<td>1,546</td>
<td>859 35%</td>
</tr>
<tr>
<td>CIGNA Healthcare of Maine, Inc.</td>
<td>4,482</td>
<td>452</td>
<td>243</td>
<td>43 (5 partials) 18%</td>
</tr>
<tr>
<td>Connecticut General Life Insurance Company</td>
<td>8,000</td>
<td>606</td>
<td>131</td>
<td>38 (1 partial) 43%</td>
</tr>
<tr>
<td>Guardian Life Insurance Company of America</td>
<td>1,59</td>
<td>33</td>
<td>17</td>
<td>9 53%</td>
</tr>
<tr>
<td>Harvard Pilgrim Health Care, Inc.</td>
<td>1,217</td>
<td>158</td>
<td>14</td>
<td>5 36%</td>
</tr>
<tr>
<td>John Alden Life Insurance Company</td>
<td>29</td>
<td>10</td>
<td>1</td>
<td>0 0</td>
</tr>
<tr>
<td>MEGALife &amp; Health Insurance Co</td>
<td>No UR</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A N/A</td>
</tr>
<tr>
<td>Secure Life Insurance Company (Dental Coverage Only)</td>
<td>No UR</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A N/A</td>
</tr>
<tr>
<td>Trustmark Life Insurance Company</td>
<td>58</td>
<td>3</td>
<td>0</td>
<td>0 0</td>
</tr>
<tr>
<td>United Healthcare Insurance Company</td>
<td>432</td>
<td>4</td>
<td>0</td>
<td>0 0</td>
</tr>
</tbody>
</table>

#### Utilization Review

Utilization Review (UR) is a program used in managed care plans that is designed to reduce unnecessary medical inpatient or outpatient services. An individual or organization, on behalf of an insurer, reviews the necessity, use, appropriateness, efficacy or efficiency of health care services, procedures, providers, or facilities.
### 2008 Health Insurance Complaint Statistics

<table>
<thead>
<tr>
<th>Total number: In 2008, consumer complaints on health insurance received by the Ohio Department of Insurance...</th>
<th>Total number: In 2008, authorized companies having health insurance premiums in Ohio...</th>
<th>Total number: In 2008, authorized companies having health insurance complaints in Ohio...</th>
<th>Total number: In 2008, complaints about health insurance involving authorized companies in Ohio...</th>
<th>Total number: In 2008, health insurers having at least ten complaints in Ohio...</th>
</tr>
</thead>
<tbody>
<tr>
<td>2,680</td>
<td>472</td>
<td>178</td>
<td>1,848</td>
<td>30</td>
</tr>
</tbody>
</table>

### Top 10 Reasons for Health Insurance Complaints in 2008

<table>
<thead>
<tr>
<th>Reason</th>
<th>Complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Claim denial</td>
<td>150</td>
</tr>
<tr>
<td>2. Unsatisfactory claim / settlement offer</td>
<td>302</td>
</tr>
<tr>
<td>3. Claim / settlement delay</td>
<td>291</td>
</tr>
<tr>
<td>4. Premium amount / rating issues</td>
<td>169</td>
</tr>
<tr>
<td>5. Coverage question / benefits out-of-network</td>
<td>117</td>
</tr>
<tr>
<td>6. Coverage / policy cancellation or non-renewal</td>
<td>78</td>
</tr>
<tr>
<td>7. Premium refund due, but not paid</td>
<td>73</td>
</tr>
<tr>
<td>8. Abusive service</td>
<td>67</td>
</tr>
<tr>
<td>9. Refusal to insure</td>
<td>82</td>
</tr>
<tr>
<td>10. Marketing / sales misrepresentation</td>
<td>46</td>
</tr>
</tbody>
</table>

Total complaints represented by the above Top 10 reasons = 2,424

> Represents 89% of the 2,787 total health insurance complaint reasons registered in 2008

### 2008 Health Insurance Complaint Ratios

**Notes:**
- Includes every company that received at least ten complaints about health insurance in 2008
- Market Share is the company’s percentage of Ohio’s total health premium in 2008
- Complaint Ratio is a comparison of the company's Ohio health premium and Ohio complaints in 2008
- We've shortened company names by omitting words like 'Insurance' and 'Company'
- * Aetna Health Inc. Ohio Corp. was folded into Aetna Life Ins. Co. in Jan. 2009
- ** Conseco Senior Health Ins. Co. changed its name to Senior Health Ins. Co. of Pennsylvania in Jan. 2009

<table>
<thead>
<tr>
<th>Health Insurers (in alphabetical order)</th>
<th>Ohio Health Premium</th>
<th>Ohio Market Share</th>
<th>Complaint to Premium Ratio</th>
<th>Total Consumer Complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna Life Ins. Co.</td>
<td>$7,492,929,747</td>
<td>6.59%</td>
<td>0.06</td>
<td>60</td>
</tr>
</tbody>
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<th>Total Consumer Complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna Life Ins. Co.</td>
<td>$1,492,929,747</td>
<td>6.56%</td>
<td>0.85</td>
<td>11</td>
</tr>
<tr>
<td>AIG Life Ins. Co.</td>
<td>$10,677,752</td>
<td>0.05%</td>
<td>0.94</td>
<td>10</td>
</tr>
<tr>
<td>American Community Mutual Ins. Co.</td>
<td>$52,316,894</td>
<td>0.23%</td>
<td>0.48</td>
<td>25</td>
</tr>
<tr>
<td>Amer. Fam. Life Assur. Co. Columbus/FLAC</td>
<td>$131,623,909</td>
<td>0.58%</td>
<td>0.47</td>
<td>62</td>
</tr>
<tr>
<td>Bankers Life and Casualty Co.</td>
<td>$42,994,938</td>
<td>0.19%</td>
<td>0.51</td>
<td>22</td>
</tr>
<tr>
<td>Community (Anheuser) Ins. Co.</td>
<td>$4,105,935,36</td>
<td>18.35%</td>
<td>0.08</td>
<td>344</td>
</tr>
<tr>
<td>Connecticut General Life Ins. Co.</td>
<td>$107,831,684</td>
<td>0.47%</td>
<td>0.13</td>
<td>14</td>
</tr>
<tr>
<td>Conseco Health Ins. Co.</td>
<td>$20,516,339</td>
<td>0.09%</td>
<td>0.73</td>
<td>15</td>
</tr>
<tr>
<td>Senior Health Ins. Co. of Pennsylvania</td>
<td>$10,665,484</td>
<td>0.05%</td>
<td>1.88</td>
<td>20</td>
</tr>
<tr>
<td>Coventry Health and Life Ins. Co.</td>
<td>$58,513,735</td>
<td>0.26%</td>
<td>0.26</td>
<td>13</td>
</tr>
<tr>
<td>Greatwest Life Ins. Co.</td>
<td>$76,571,174</td>
<td>0.31%</td>
<td>0.84</td>
<td>59</td>
</tr>
<tr>
<td>Golden Rule Ins. Co.</td>
<td>$63,961,818</td>
<td>0.28%</td>
<td>0.25</td>
<td>16</td>
</tr>
<tr>
<td>Humana Health Plan of Ohio Inc.</td>
<td>$279,244,273</td>
<td>1.22%</td>
<td>0.16</td>
<td>45</td>
</tr>
<tr>
<td>Humana Ins. Co.</td>
<td>$76,075,116</td>
<td>3.25%</td>
<td>0.09</td>
<td>63</td>
</tr>
<tr>
<td>Kaiser Foundation Health Plans of Ohio</td>
<td>$555,537,960</td>
<td>2.44%</td>
<td>0.03</td>
<td>18</td>
</tr>
<tr>
<td>Life Ins. Co. of North America</td>
<td>$55,996,092</td>
<td>0.24%</td>
<td>0.59</td>
<td>32</td>
</tr>
<tr>
<td>Lincoln National Life Ins. Co.</td>
<td>$46,395,227</td>
<td>0.20%</td>
<td>0.24</td>
<td>11</td>
</tr>
<tr>
<td>Medical Mutual of Ohio</td>
<td>$1,773,255,517</td>
<td>8.65%</td>
<td>0.11</td>
<td>213</td>
</tr>
<tr>
<td>mega Life &amp; Health Ins. Co.</td>
<td>$35,995,727</td>
<td>0.15%</td>
<td>0.28</td>
<td>10</td>
</tr>
<tr>
<td>Metropolitan Life Ins. Co.</td>
<td>$131,491,001</td>
<td>0.75%</td>
<td>0.12</td>
<td>21</td>
</tr>
<tr>
<td>National Union Fire Ins. Of Pittsburgh</td>
<td>$10,795,575</td>
<td>0.05%</td>
<td>1.48</td>
<td>16</td>
</tr>
<tr>
<td>Nationwide Life Ins. Co.</td>
<td>$41,637,583</td>
<td>0.18%</td>
<td>0.34</td>
<td>14</td>
</tr>
<tr>
<td>Paramount Care Inc.</td>
<td>$394,423,952</td>
<td>1.55%</td>
<td>0.06</td>
<td>20</td>
</tr>
<tr>
<td>Pyramid Life Ins. Co.</td>
<td>$26,313,081</td>
<td>0.27%</td>
<td>0.24</td>
<td>15</td>
</tr>
<tr>
<td>Time Ins. Co.</td>
<td>$34,974,128</td>
<td>0.15%</td>
<td>0.47</td>
<td>16</td>
</tr>
<tr>
<td>United American Ins. Co.</td>
<td>$44,538,642</td>
<td>0.20%</td>
<td>0.65</td>
<td>29</td>
</tr>
<tr>
<td>United Healthcare Ins. of Ohio</td>
<td>$526,427,080</td>
<td>2.31%</td>
<td>0.10</td>
<td>51</td>
</tr>
<tr>
<td>United Healthcare Ins. Co.</td>
<td>$1,271,374,015</td>
<td>5.58%</td>
<td>0.09</td>
<td>109</td>
</tr>
<tr>
<td>United Healthcare of Ohio Inc.</td>
<td>$659,142,159</td>
<td>3.07%</td>
<td>0.04</td>
<td>28</td>
</tr>
<tr>
<td>Unum Life Ins. Co. of America</td>
<td>$117,821,454</td>
<td>0.52%</td>
<td>0.13</td>
<td>15</td>
</tr>
<tr>
<td><strong>Total Carriers Above / 2008</strong></td>
<td><strong>$13,256,190,899</strong></td>
<td><strong>68.13%</strong></td>
<td><strong>0.11</strong></td>
<td><strong>1,416</strong></td>
</tr>
<tr>
<td><strong>All Ohio Health Carriers / 2008</strong></td>
<td><strong>$22,804,363,350</strong></td>
<td><strong>100.0%</strong></td>
<td><strong>0.08</strong></td>
<td><strong>1,848</strong></td>
</tr>
</tbody>
</table>
APPENDIX

List of Health Plan Report Cards Reviewed

CA Cooperative Healthcare Reporting Initiative (CCHRI)
http://www.cchri.org/reports/hp_report_card.html
HMO and PPO report cards published by collaborative of health care purchasers, plans and providers includes
HEDIS information. HEDIS and CAHPS information provided for both commercial and Medicare plans.

CA Dept. of Health Care Services- Medicaid
http://www.dhcs.ca.gov/individuals/Pages/MMCDConsumerGuide.aspx

CA Office of the Patient Advocate
CA state government site that provides a broad range of information about HMOs and PPOs including
HEDIS and patient satisfaction. Uses star rating system. Thru portal, also includes information about
hospitals and medical groups.

CA- CalPERS
http://www.calpers.ca.gov/index.jsp?bc=/member/health/home.xml
Website for active and retired members of California state government. Provides information about plan
options, including plan satisfaction.

CO Business Group on Health
http://www.cbghealth.org/cbg/index.cfm?LinkServID=E049392D-D33F-F20A-
D2ED70858A72E914&showMeta=0
A “Health Matters” PDF report that includes range of information on health plans including HEDIS and
CAHPS. Also includes information on hospitals, physicians and general health information.

CO Division of Insurance
http://www.dora.state.co.us/pls/real/Ins_Comp_Ratio_Report.Home
Complaint ratios and indices.

CT Business and Industry Association
http://www.cbia.com/ieb/er/default.htm
A association of CT employers that offers a health insurance program to employers with 3 or more
employees. Employees of those participating can pick from several different plan options.

CT Insurance Dept.
State PDF report that provides comparative HEDIS and CAHPS information about commercial HMOS. Also
includes information on appeals and medical loss ratio.

b) http://www.catalog.state.ct.us/cid/portalApps/examinations.aspx
Link to market conduct reports.

FL Agency for Health Care Administration
http://www.floridahealthfinder.gov/HealthPlans/
State interactive report card that provides HEDIS and CAHPS information about commercial, Medicaid,
Medicare, and Healthy Kids HMOs in the state.
Employer report card that includes results based on the eValue8 tool including information on health plan’s performance regarding consumer engagement, provider measurement, chronic disease management and prevention.

GA Dept. of Community Health
http://georgiahealthinfo.gov/cms/compare_health_plans
Georgia HealthInfo website that includes information on HEDIS and CAHPS for commercial, Medicaid and the GA CHIP plan, as well as information about hospitals, long term care facilities and other health facilities. (Note: This site was taken down in Jan. 2011 due to state budget issues)

IL Dept. of Insurance
a) http://www.insurance.illinois.gov/Complaints/healthCarePlan_complaints/HealthCarePlanComplaints09.asp
Company complaints and external reviews.

b) http://insurance.illinois.gov/Reports/special_reports/IMMHPRFRG.pdf
Guide to IL Dept. of Insurance Individual Major Medical Health Policy Rate Filing Report

IN Dept. of Insurance
http://www.in.gov/idoi/2551.htm
Complaint index

KY Dept. of Insurance
http://insurance.ky.gov/Complaints/default.aspx
Complaint ratios.

LA Dept. of Health & Hospitals
Louisiana HealthFinder site provides information about HEDIS and CAHPS data for commercial and Medicaid HMOs and PPOs, as well as information about hospitals, nursing homes and other health facilities.

MA Health Connector
https://www.mahealthconnector.org/portal/site/connector/
Website that provides information to all MA residents and employers about their options under MA health reform. Includes report card about plan options that utilizes star ratings.

MA Health and Human Services
http://www.mass.gov/?pageID=eohhs2terminal&L=5&L0=Home&L1=Researcher&L2=Insurance+(including+MassHealth)&L3=Managed+Care+Protections+and+Grievances&L4=Annual+Reporting+Requirements+for+Massachusetts+Health+Plans&sid=Eeohhs2&b=terminalcontent&f=dph_patient_protection_r_annual_report_data09&csid=Eeohhs2
Annual reporting information including premium revenue used for health care services, external appeals, grievances and voluntary and physician termination

MA Office of Patient Protection
http://www.mass.gov/?pageID=eohhs2terminal&L=5&L0=Home&L1=Researcher&L2=Insurance+(including+MassHealth)&L3=Managed+Care+Protections+and+Grievances&L4=Ext
Statistics about numbers of external plan reviews.

**MD Health Care Commission**

MD state PDF report that provides star ratings of HMO/POS and PPO plans in the state. Also includes measures from eValue8—measures that access health plan programs including consumer engagement, preventive care, and disease management.

b) [http://mhcc.maryland.gov/hmo/stateemployeeguide.pdf](http://mhcc.maryland.gov/hmo/stateemployeeguide.pdf)
State employee guide.

**MD Dept. of Health & Mental Health (Medicaid)**

MD Insurance Administration


**ME Bureau of Insurance**

Utilization review and complaint information.

**MI Alliance for Health (and MI Purchasers Health Alliance and Greater Detroit Area Health Council)**

[http://www.afh.org/doc/FINAL%20EV8%20CONSUMERS%20GUIDE%202010-30-08.pdf](http://www.afh.org/doc/FINAL%20EV8%20CONSUMERS%20GUIDE%202010-30-08.pdf)
Two page brochure that provides limited information from HEDIS, CAHPS and eValue8.

**MI Dept. of Community Health - Medicaid**


**MI Office of Financial and Insurance Regulation**

Provides star ratings of HMOs for 2008 and 2009 based on NCQA categories, accreditation and complaint information.

**MN Dept. of Commerce**

Report on loss ratios in individual and small group market.

**MN Dept. of Health**

[http://www.health.state.mn.us/divs/hpsc/mcs/hmo.htm](http://www.health.state.mn.us/divs/hpsc/mcs/hmo.htm)
Provides a variety of information about health plans including their 990 IRS form which includes executive compensation, most recent financial examination, quality assessment exam and technical HEDIS information.

**MN Community Measurement**

Provides information on cost of care for doctors for a variety of procedures.

**MO Dept. of Insurance, Financial Regulation & Professional Registration**
http://insurance.mo.gov/consumers/complaints/compindx.php
Consumer complaint report

**NC Dept. of Insurance**
http://www.ncdoi.com/Consumer/consumer_ratios.asp
Compliant ratios.

**NE Dept. of Insurance**
http://www.doi.ne.gov/legal/coaction/coaction.htm
Current company disciplinary actions.

**NH Insurance Dept.**
http://www.nhhealthcost.org/
Provides information on the price of medical care by insurance plan and procedure for both insured and uninsured.

**NJ Dept. of Banking and Insurance**
http://www.state.nj.us/dobi/lifehealthactuarial/hmo2010/index.html
NJ state report card in both an interactive and pdf format that contains comparative HEDIS and CAHPS data.

**NM Health Policy Commission**
Two page brochure that provides star ratings of HEDIS and CAHPS information and accreditation status.

**NY Insurance Dept. and NY Dept. of Health**
http://www.ins.state.ny.us/hgintro.htm
NY Guide to Health Insurers (2010) that includes a variety of information including complaints, appeals, accreditation, HEDIS and CAHPS information.

**NY State Health Accountability Foundation**
http://hcrc.abouthealthquality.org/
Website that provides HEDIS and CAHPS information about health plans in CT, NJ, NY, RI and VT.

**OH Dept. of Insurance**
Health insurance complaints

**OR Dept. of Consumer and Business Services**
Health insurance company complaints

b) http://www.oregonhealthrates.org/
Interactive database where consumers can review rate increase requests for individual and small group health insurance plans.

**OR Health Authority-Office of Health Policy and Research**
http://www4.cbs.state.or.us/ex/ins/hit/
Allows users to compare hospital costs based on average payment information from health plans

PA Dept. of Public Welfare – Medicaid
http://www.dpw.state.pa.us/ucmprd/groups/public/documents/communication/s_002194.pdf

PA Health Care Cost Containment Council
a) http://www.phc4.org/reports/mcpr/06/default.htm
2006 report that includes HEDIS, CAHPS and utilization information about commercial HMOs. Also allows ability to customize report based on a database of information.

2007 report on Medicare Advantage plans in PA that provides general information about how plans work and HEDIS and CAHPS data.

RI Insurance Commission & RI Dept. of Health
2008 report that provides HEDIS, CAHPS, utilization and medical expense/administrative expense/profit cost data on commercial plans in RI.

SC Dept. of Health & Human Services - Medicaid
http://www.scdhhs.gov/QualityReports.asp

TN Dept. of Commerce and Insurance
http://tn.gov/commerce/insurance/hmostats.shtml
HMO statistics

TN-HealthCare 21 & Memphis Business Group on Health
A Guide to TN Health Plan Performance that includes comparative information based on the results of the eValue8 employer tool.

TX Office of Public Insurance Counsel
http://www.opic.state.tx.us/page.php?p_sub_page_id=81
Report provides information on CAHPS, patient and provider complaints and appeals.

US-Centers for Medicare and Medicaid Services
https://www.medicare.gov/find-a-plan/questions/home.aspx
Medicare Plan Finder

US- Consumer Reports Health Plan Information
http://www.consumerreports.org/health/insurance/health-insurance.htm
Site provides NCQA HEDIS and CAHPS data on over 225 HMOs and HMO/POS plans. Also provides rating to 41 PPO plans based on CU reader survey. Must be subscriber to view information.

US-Consumers’ CHECKBOOK
Guide to Health Plans for Federal Employees & Annuitants (Requires subscription)
http://www.checkbook.org/newhig2/hig.cfm
Offers cost, benefit and quality (CAHPS) information for federal employees. Includes cost-calculator based on estimated low, average or high utilization.

US Dept. of Health and Human Services
http://www.healthcare.gov/
Find insurance options nationwide.
US-Federal Employees Health Benefit Program
Plan information for 2010

US-National Assoc. of Insurance Commissioners (NAIC)
hits://eapps.naic.org/cis/
Company search for complaint and financial information

US- NCQA Health Plan Report Cards
http://reportcard.ncqa.org/plan/external/
Nationwide database of HMO, HMO/POS and PPO commercial, Medicare and Medicaid health plans that includes star ratings based on accreditation information, HEDIS and CAHPS

UT Dept. of Health
http://health.utah.gov/myhealthcare/healthplan.htm#quality
UT state report card that provides HEDIS and CAHPS data about commercial HMOs.

UT Health Exchange
http://www.exchange.utah.gov/
UT government-sponsored website that provides access to health insurance for small employers (at least 2 employees). Allows employees to choose from among several plans.

VA Dept. of Medical Assistance - Medicaid

VT Dept. of Banking, Insurance, Securities and Health Care Administration
http://www.bishca.state.vt.us/health-care/health-plan-report-card
Booklet that provides HEDIS and CAHPS information, including performance over time.

WA Office of the Insurance Commissioner
https://fortress.wa.gov/oic/complaints/
Complaint comparison tool.

WA – Puget Sound Health Alliance
Provides comparative health plan results based on the eValue8 survey.

WI Collaborative for Healthcare Quality
http://www.wchq.org/reporting/
Website that provides health plan information on HEDIS and CAHPS as well as information on hospitals and physician groups.

WI Dept. of Employee Trust Funds
http://etf.wi.gov/members/benefits_state_health%20.htm
It's Your Choice 2011 Decision Guide

WI Dept. of Health Services – Medicaid

WI Health Insurance Exchange
https://exchange.wisconsin.gov/exchange/
A prototype website that does not include real data, but provides information and tools that might be used as the exchange is implemented in the future.
WI Office of the Commissioner of Insurance
http://oci.wi.gov/pub_list/pi-044.pdf
Report provides information on HEDIS and CAHPS for HMOS and grievances for HMOs and PPOs.

WY Insurance Dept.
http://insurance.state.wy.us/consumer.html
Consumer health insurance complaints