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Liberating Data to Enable Healthcare Market Transparency:

A Guide for Regulators and Policy Makers

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Executive Summary

The federal and state Marketplaces established by the Affordable Care Act (ACA) have made it easier for consumers to compare their health insurance options, but data are still not fully available for consumers to understand how their plan options compare on cost-sharing, provider networks, drug access, and what each option might cost them in premiums and out-of-pocket spending. The challenges are more daunting for consumers who purchase coverage outside the Marketplaces, where comparative data are harder to find and consumer tools are more limited.

Despite these limitations, however, the road ahead is clear: we are on the cusp of a transparency revolution in which consumers will have the data and the consumer tools to make informed choices among their health insurance options in ways that will transform the Marketplace. Consider the following scenarios:

- A person with diabetes uploads his electronic medical records and biometrics from his wristband to a consumer tool that matches this individualized data against all available health plans and within minutes provides detailed plan rankings based on expected cost (premium and predicted cost-sharing), provider and drug access, patient satisfaction ratings, or other factors of the person's choosing.
- A millennial in a hurry enters her age and zip code into a mobile app and within seconds can view the three cheapest plans by premium in her area. The app encourages her to enter income to see whether she is eligible for a subsidy and health data to estimate her out-of-pocket expenses.

The **Roadmap to Transparency** describes the steps that public officials and private stakeholders can take to realize the full benefits of a Marketplace in which consumers have ready access to online decision-making support tools that:

- Allow electronically searchable plan comparisons by plan characteristics, including benefit design, cost-sharing, network, and formulary.
- Allow – but do not require – consumers to input personal data into the tool, including health conditions, prescriptions, and provider preferences.
- Allow – but do not require – consumers to elect auto-uploads from medical records/claims as well as wearable devices, such as heart-rate monitors, to auto-enable recommendations of the best plan based on the consumer's unique preferences.

The **Roadmap** focuses primarily on the foundational step of making health plan information available in a standardized and timely manner so that the designers of consumer tools have full access to the data necessary to develop robust decision-support tools. The data are already being collected by state and federal regulators, some of it in machine-readable formats that are readily usable for app development. The rest of it could be made equally accessible, though it will take a concerted effort to ensure the data meet six key criteria for data quality:

- *Accurate* – verified information that reflects actual plan offerings.
- *Complete* – available on all plan offerings in all relevant product categories.
- *Consistent* – available in standard formats that allow for apples-to-apples comparisons.
- *Accessible* – publicly available so that tool designers compete on a level playing field to use the data to fashion consumer tools.
- *Process-able* – available in machine-readable formats that can be easily manipulated, so that tool designers can turn an overwhelming amount of data into consumer-friendly decision-making tools.
- *Timely* – available in advance of open enrollment.

The **Roadmap** outlines a three-pronged strategic approach to achieving the requisite data quality and ensuring that consumers are able to benefit from the results:

- Take concrete actions to make key data on plan design, provider networks, and formularies available to app developers;
- Continue to focus on developing a regulatory environment that promotes innovation in app development, safeguards consumers' privacy rights, and ensures fair competition; and,
- Develop consumer literacy campaigns that promote consumer use of health-related apps and other decision-making tools to understand their options and make choices that most find bewildering today.

The **Roadmap** concludes with four recommendations designed to establish the data foundation for a transparent and consumer-oriented Marketplace by 2020:

- Federal and state regulators should work together to make full data on all Marketplace plans publicly available in machine-readable standardized formats at least 60 days prior to open enrollment each year.
- State insurance regulators, with the assistance of the National Association of Insurance Commissioners (NAIC), should ensure that the same plan data that are made available for public Marketplaces are made available in the same machine-readable standardized formats for the rest of the individual and small group markets.
- U.S. Department of Health and Human Services (HHS) and state officials should jointly convene an advisory group of public and private experts to establish best practices and, potentially, regulatory standards for the use of data by choice-enabling applications.
- State and federal officials should collaborate with private payers to expand access to large claims databases and to pricing and quality data on medical services.

Introduction

The Affordable Care Act creates powerful mechanisms for consumers to compare benefits, provider networks, and formularies when making their choice of health plan. Ideally, these mechanisms provide consumers the right data along with appropriate decision-making tools to allow them to make the best cost-value-access decision for themselves and their families. However, given the complex nature of insurance benefit designs, the variation in provider networks and plan formularies, and the uncertain prognosis for most individual health needs, making an informed plan choice is, under the best of circumstances, a difficult proposition. In order for individuals and families to be able to make informed choices, consumers must be able to compare plans on a variety of factors, including premiums, cost-sharing, quality, provider access, and formulary design and composition.

Over the last few years, the federal Marketplace, through Healthcare.gov, and State-Based Marketplaces (SBMs) have made noticeable improvements in the timeliness, completeness, and accuracy of website-based data on plan design, premiums and cost-sharing, networks, and formularies. In addition, the Marketplaces – and private vendors – have introduced a set of new decision-making tools. A number of consumer and patient advocacy groups have reviewed these websites for usability, and continue to provide recommendations on improving their usability for consumers. In this paper, we look behind these websites and examine the underlying source plan and benefit data provided by plans and regulators and used by Marketplace applications.

We conclude that for Marketplaces to have the necessary data to continue to improve the consumer experience, it will be incumbent on state insurance regulators to make steady progress in opening up Marketplace and non-Marketplace access to high-quality data for individuals and small businesses that purchase health insurance both within and outside the Marketplaces. Without these dual and parallel efforts at the state level, there will be major data gaps, since nationally the off-Marketplace market is 57% of the individual market and more than 95% of the small group market.¹ Fortunately, the parallel effort is certainly feasible, since the same electronic filing system (SERFF) is used to file and store plan data in most states for the Marketplace and the outside market. Although few states have made the same efforts as the Centers for Medicare and Medicaid Services (CMS) has to make the data accessible and process-able, many regulatory standards apply across the entire market, and where there are differences the states have the same interest as the federal government to make data available and promote an improved consumer experience.

Even with consistent data and advanced decision-support tools, consumers' ability to make informed decisions depends on their ability to understand the insurance market, the role of network design and, for those dependent on medications, the importance of a plan's formulary design. Continued efforts to increase consumers' "health plan literacy" are essential to realize the promise of Health Insurance Marketplaces.

Much more can be done and much more must be done. State and federal regulators should work together with private-sector partners to agree upon and implement a four-year **Roadmap to Transparency** to allow consumers to make fully informed decisions that address their unique healthcare needs, and that reflect their unique preferences across the dimensions of total cost, quality, and access. As we describe below, the **Roadmap** should describe the changes needed to make sure consumers have the right information at the right time to make informed decisions on choice of plan design, choice of formulary, choice of network, choice of provider, and the cost of treatment, ideally including comparative costs when consumers are asked to choose between competing treatments.

Eventually, a vibrant Health Insurance Marketplace should also enable consumers to incorporate personal preferences on physician and hospital choices, to examine the estimated cost of a particular treatment or service across competing providers and/or health plans, and to include these estimates – and the associated out-of-pocket liabilities – in the decision-support tool calculations. Given the significant challenges associated with developing consumer-specific provider quality and treatment cost metrics, our paper focuses on the still considerable opportunities for better plan data and better decision-support tools.

The **Roadmap to Transparency** envisions a destination where consumers have ready access to *decision-support tools* that:

- Allow plan comparisons by plan characteristics. This means all relevant plan data (benefit design, cost-sharing, network, formulary structure and detail) are searchable electronically;
- Allow – but do not require – consumers to include personal data (e.g., health conditions, prescriptions, hospital preferences) in the decision-making tool; and
- Allow – but do not require – consumers to elect auto-uploads from medical records or claims, as well as data wearables (e.g., heart-rate monitors), to auto-enable a decision-making tool to recommend the best plan, network, formulary, etc.

Eventually, consumers should *also* have access to tools that:

- Allow consumers to assess and screen for the reported quality of providers, and to determine which plan's network is best for their needs.
- Allow consumers to compare the cost of different treatment options (e.g., how much will knee surgery cost versus alternative treatments).

A Roadmap to Transparency

"If you don't know where you are going, you'll end up someplace else." — Yogi Berra

The 2020 Vision

Consumers have different health needs and priorities and vary in their comfort with sharing data electronically. For the Health Insurance Marketplace to function effectively, consumers need access to different tools that help them answer their coverage questions, and the tools must respect the autonomy of the consumer's preferences. One size does not fit all.

By 2020, consumers should be able to use a decision-making tool or multiple tools as envisioned in each of the following scenarios:

- Bob is looking for the best health plan to help him manage his diabetes. He has his medical records in electronic form as well as detailed biometrics from his wearable devices, and picks an app that allows him to upload both data sets and match them against all individual plans available in his county. In less than a minute, the app sends three recommendations to his tablet: one that is projected to be cheapest, taking

into account premium and projected cost-sharing; a second that includes all his current providers at a higher cost; and a third that has the highest patient satisfaction scores among people with diabetes.

- Shoshana is worried about her privacy, so she picks an app that ranks all plans available to her without requiring much information from her. Her ranking options include by premium price only, by estimated annual cost (based on her age and county, with an invitation to add medical history for a more refined estimate), and by quality (based on a five-star rating system). She decides to add limited information about her prescriptions and medical history and is surprised to see her estimated annual cost increase and dramatically change the ranking of plans by annual cost.
- Carlos is a millennial in a hurry and selects an app that gives him a single "best choice" plan based on his age, county and two questions about his price and quality preferences.

- Jasmine is choosing coverage for her entire family through the Marketplace. Her husband has high cholesterol. Her teenage son has asthma and her 24-year-old daughter has a lingering knee injury from playing college soccer and is still on the family plan. Jasmine needs a tool that will balance all of the health needs of her family to help her choose the best coverage.

Realizing the Vision: A Four-Year "Roadmap to Transparency"

We are on the cusp of a transparency revolution that will transform the way in which consumers choose among health insurance plans, including formularies, healthcare providers, and healthcare services. Based on our interviews with application developers, today, no choice-enabling application can yet satisfy the varying needs of Bob, Shoshana, Carlos, and Jasmine. Our research indicates that the rate-limiting factor to developing these kinds of consumer-centric solutions is not the programming or decision-logic, but rather the **lack of quality data** to

match consumer preferences to available health plans, networks, formularies, and providers. In examining this lack of data, our review of federal, state, and private insurance plan databases confirmed that the underlying data is, in fact, being collected today, some of it in machine-readable formats that are readily usable for research and app development purposes; the rest of it could be made equally accessible. However, the data is not yet of the quality – broadly defined – necessary to optimize the development of choice-enabling applications. Thus, to accelerate the development of Marketplace decision-support tools, there is little need to collect and store *new* data; rather, we face the challenge of liberating *existing* data.

This paper focuses primarily on the foundational step in that transparency revolution: making health plan information – already being collected by state and federal regulators – available publicly and in a timely manner so that all developers and consumers have access to the information to permit development of robust decision-support tools, and to enable informed decisions by consumers.

The *institutional* data and information needed includes annual data on plan benefits, premium prices, and cost-sharing provisions; and regularly updated data on network providers, provider quality, and formulary design and composition. None of these data sets involve *personally identifiable* information. All of these data sets are – in theory – available, albeit housed in different agencies, and many are not updated on a timely basis, owing to structural interdependencies (e.g., accurate network addresses depend on timely notification from physicians about moving or adding offices).

With consumers being asked to take on more responsibility to make informed choices regarding their insurance plans, their providers and their courses of treatment, the policy goal should be to make available to consumers and developers all relevant information on plan design, plan pricing, provider networks, and formulary design. Below, we describe a path forward to reach this next stage in consumer-enabling healthcare information, where public and private entities:

1) Take concrete actions to make key data on plan design, provider networks, and

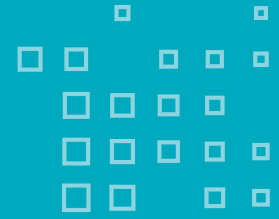
formularies available to app developers;

- 2) Continue to focus on developing a regulatory environment that promotes innovation in app development, safeguards consumers' privacy rights, and ensures fair competition; and
- 3) Develop consumer literacy campaigns that promote consumer use of health-related apps and other decision-making tools to understand their options and make choices that most find bewildering today.

Below, we discuss each of these three initiatives, which together comprise the **Roadmap to Transparency**.

Section 1

Making Plan Data Available



The first crucial step toward our 2020 vision is for the state and federal regulators who collect the needed data to make it available in formats that meet six criteria, adopted from common definitions of “data quality”:

- A. *Accurate* – verified information that reflects actual plan offerings.
- B. *Complete* – available on all plan offerings in all relevant product categories.
- C. *Consistent* – available in standard formats that allow for apples-to-apples comparisons.
- D. *Accessible* – publicly available so that tool designers compete on a level playing field to use the data to fashion consumer tools.
- E. *Process-able* – available in machine-readable formats that can be easily manipulated, so that tool designers can turn an
- F. *Timely* – available in advance of open enrollment.

overwhelming amount of data into consumer-friendly decision-making tools.

Against these criteria, we can report some progress, but much more is needed in order to make plan, network, and formulary data available that meet these criteria. The chart below provides a **Scorecard** (green is best, red is worst) of Marketplace-relevant data,

Institutional Marketplace Data from Regulators: A Preliminary Scorecard

	1. Covered Benefits	2. Cost-Sharing	3. Premium	4. Network	5. Formulary
A. Accurate					
B. Complete					
C. Consistent					
D. Accessible					
E. Process-able					
F. Timely					

assessed against the six dimensions of data quality. Below we provide a qualitative summary of the current state of the Marketplace-relevant data.

Overview

Data on benefits, including formularies, and costs are necessary to determine and compare which benefits are offered as well as what costs are under each plan. These data are also critical to designing tools that estimate total annual costs of plans under different health scenarios.

The quality of data across the five identified categories varies, with considerable opportunity for improvement. For FFM states and many SBMs, the data are *collected* in a **Timely** manner: benefit plans are given final approval in August for the following benefit year. While there are minor changes after this and some carriers withdraw their plans later, the data is basically in final form two months before open enrollment begins. Although there are a few states that do not have the same timeline, there is effort under way to get all states on this timeline.

The data are also, for the most part, **Complete** and **Consistent**. State Departments of Insurance (DOI) have the most complete data sets through the State Electronic Rate and Form

Filing (SERFF) system, since all individual and small group plans, on and off the Marketplace, must be filed with and approved by the states (except where the state has deferred on Marketplace approval to CMS). This makes SERFF filings the most complete database with the federal filings through the Health Insurance Oversight System (HIOS) as a supplementary database in some cases. SERFF and HIOS have consistent data standards and templates.

However, the data are not fully **Accurate** – the filed data frequently have errors. Oregon has developed a process for making the data sets it intends to publish available to the carriers for a quick opportunity to correct mistakes. There may be other approaches than carrier verification, but regulators do need to agree on protocols that ensure data accuracy. Additionally, while benefits and cost-sharing are typically static for the year, formularies can change midyear when new drugs become available. Nor are the data generally **Accessible** – CMS and State Departments of Insurance must agree on protocols to make the data in their possession by late August publicly available shortly thereafter so that app makers have two months before public enrollment to develop their

tools. CMS does produce files (PUF files) now that are an infant version of standardized data, but these files are far from timely.

Finally, not all of the released data are **Process-able** – for use by developers, all data must be in a standardized machine-readable format. There are signs of progress, but more needs to be done across the categories of data. For example, new standards for machine-readable formularies were implemented for the third open enrollment period in the FFM, which will enable increasingly sophisticated tools for sorting QHPs by designated drugs and by insurer practices, such as tiered pricing and utilization management rules, which impact access. In addition, new requirements to detail cost-sharing amounts will help consumers understand the amount of cost-sharing they are likely to pay.

Data for plans sold in the individual market outside the Marketplaces should, in theory, be equally timely, complete, consistent, and accurate since the same SERFF system is used in most states. However, few states have made the same efforts as CMS has to make the data accessible and process-able. This is a major gap that must be addressed, since nationally, the off-Marketplace market is 57% of

the individual market and more than 95% of the small group market.²

Below, we discuss the five data categories in more detail:

1. Covered Benefits Data

Covered benefits have been significantly standardized through selection of benchmark plans in each state that define the Essential Health Benefits (EHBs) that must be covered. However, plans can include additional benefits and there are minor variations in EHBs on a plan-by-plan basis that still require each separate benefit plan to meet the six data criteria. In fact, it is precisely in the narrow areas where plans vary that the benefit data are most likely not to be accurate, complete, and consistent.

Recommendations

- **Federal:** Continue efforts to clarify minimum standards for EHBs that reduce unintended plan variation, and where variation is explicitly allowed (e.g., additional benefits), develop protocols that promote complete and consistent data.
- **States:** Require plans outside the Marketplaces to meet the same data standards as Marketplace plans. Continue to clarify state standards within federal parameters,

and develop protocols that promote complete and consistent data.

- **Plans:** Define benefits in as complete and consistent a fashion as possible.
- **Providers:** Identify areas of ambiguity and offer solutions.
- **Researchers:** Identify problems in EHB coverage and offer solutions that reduce ambiguity.

2. Cost-Sharing Data

Actuarial cost-sharing levels and specific cost-sharing data have been somewhat standardized through the four metal levels, and some states, notably California and New York, have further standardized cost-sharing. However, insurers still have broad flexibility to vary cost-sharing, which makes it imperative that the cost-sharing data for each benefit plan meet the six data criteria.

Recommendations

- **Federal:** Assess whether the recent decision to standardize cost-sharing on a voluntary basis facilitates shopping without unduly limiting innovation.³
- **States:** Require plans outside the Marketplaces to meet the same standards as Marketplace plans.
- **Plans:** Define cost-sharing in

as complete and consistent a fashion as possible. Eliminate minor variations in cost-sharing to minimize consumer confusion.

- **Providers:** Identify areas of ambiguity and offer solutions.
- **Researchers:** Identify best practices in cost-sharing and offer solutions that reduce confusion.

3. Plan Premium Data

Premiums (the price of the benefit package) are single data points that meet all the data standards once they are available. From a data standpoint, the main issue with premiums is when they are available. Ideally, they should be available at the same time as other plan data, but the FFM has not been disclosing them until shortly before open enrollment. Most states, including most FFM states, do their own rate review and some states disclose premiums much earlier in the process. This is not a problem from a data standpoint; the data issue is that federal and state regulators move forward to disclose premiums along with all other plan data at least 60 days prior to open enrollment.

Recommendations

- **Federal:** Disclose premiums for FFM states no later than the public release of all other plan data.

- **States:** Meet the federal timeline in states that do their own rate reviews, and apply the same timeline to plans outside the Marketplace as to Marketplace plans.
- **Plans:** Comply with federal and state timelines for submission of rating data.

4. Network Design and Composition Data

After price, the most common consumer concern is access to preferred providers.⁴ Efforts to make the data **Accurate, Timely, Accessible** and **Process-able** are under way. Last year, CMS increased federal standards to make provider directories more accurate, and new standards for machine-readable provider directories were implemented in the third open enrollment period, which will enable increasingly sophisticated tools for sorting QHPs by designated doctors, proximity of specialty care, and relative scope of network. With wide variation in network strength across Marketplace plans, states will be taking a careful look at the NAIC's new Network Adequacy Model Act and new CMS guidance to decide how best to regulate network adequacy at the state level.^{5,6} States will be deciding whether to impose quantitative time and distance standards, how to handle tiered networks, and

whether consumers should be protected against certain out-of-network charges.

Nonetheless, there are trade-offs between price and networks, and surveys suggest that consumers are less concerned with broad networks (a recent Kaiser survey found that 87% of enrollees were very or somewhat satisfied with choice of providers in their plans)⁷ than new enrollees are with being sure that their current providers are in-network and/or that listed providers are taking new patients. In fact, some plans with narrow networks may have superior quality because of a more integrated system. As mentioned in a recent *Health Affairs* article, a measure for coordinated care might be more meaningful (e.g., examining how frequently providers in a plan network share patients with one another).⁸ The same article also suggested network stability from year to year as another important consideration. As insurers and providers experiment with new risk-sharing arrangements, network strength will continue to be a key consumer concern and will likely give rise to various proposals for evaluating networks (perhaps through a star rating system), as well as more detailed requirements for provider directories.

More analysis should be done to determine what questions

consumers want answered about network coverage. Thus, data to answer all consumer questions about networks are not **Complete**, as more data in areas such as care coordination, providers accepting new patients, network turnover, and other areas would be useful.

Recommendations

- **Federal:** Continue efforts to establish minimum standards of accurate, consistent, machine-readable network data that must be reported to all Marketplaces. Data should be available in a timely way to app developers and consumers. The federal government should also work with states and researchers to determine other salient data needs or requirements.
- **States:** Require plans outside of Marketplaces to provide timely network data consistent with Marketplace data.
- **Plans:** Update directories regularly and report data in machine-readable formats so that they can be integrated with other data and used to compare plans.
- **Providers:** Provide routine updates to plans about participation. As other data requirements are established (e.g., accepting new patients, coordination efforts), these

also must be reported and updated regularly.

- **Advisory Board:** An Advisory Board, with researchers and other experts, charged with determining critical network questions and best practices, would improve the utility of consumer tools.

5. Formulary Design and Composition Data

CMS made strides this year by requiring Qualified Health Plans (QHPs) to provide formulary and cost-sharing details so that consumers can determine how their medicines may be covered (machine-readable data required for the FFM). In addition, Healthcare.gov offered a new search tool to help consumers sort through the new information in an efficient manner. Although there are improvements needed

to make formulary search fully consumer-friendly in Healthcare.gov, the consumer experience for the 38 states that rely on Healthcare.gov has been vastly improved. The FFM site includes, as of the third open enrollment period, an integrated prescription drug directory that pulls information from plans' formularies when the consumer enters a particular drug name. Unfortunately, most of the 12 states (plus DC) that rely on their own SBM sites do not provide this feature.

Requiring all QHPs to provide machine-readable formulary data will make data **Process-able, Complete, Consistent** and more **Accessible** for Marketplace coverage.

As described in the benefit and cost-sharing section, more work needs to be done to make

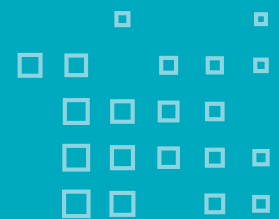
sure the data are released in a timely manner, in advance of open enrollment, and that the data are **Accurate**. Like network data, frequent updates are necessary, as formularies can change midyear when new drugs become available.

Recommendations

- **Federal:** Require all QHPs to report formulary and cost-sharing data in machine-readable formats, and release data far enough in advance of open enrollment so that formulary search tools can be developed.
- **States:** Require plans outside of the Marketplace to meet the same standards as the QHPs.
- **Plans:** Meet requirements and report updates in a timely manner.

Section 2

Facilitating a Competitive Market



The data sets described in Section 1 are complex and not readily usable by most consumers, even with the ACA's requirement that all benefit plans cover the same set of "essential health benefits" (EHBs) and

provide comparability in actuarial value across four levels of cost-sharing obligations. Some states, notably California and New York, have added further standardization to simplify consumer choice

and reduce the potential for discriminatory benefit designs, and recently, CMS has proposed additional standardization on a voluntary basis for the FFM.

There is considerable evidence that optimal consumer choice

depends on the consumer having a relatively limited set of choices, which might suggest that all Marketplaces should follow the model of large employers, who routinely design a set of benefit choices for their employees that present a few standard choices. For a variety of reasons, however, even the public Marketplaces that have standardized choices (e.g., CA and NY) provide a broader range of choice than the typical large employer. In part, this reflects the public-facing role of Marketplaces; the policy issues associated with increasing the standardization of Marketplace plan design are beyond the scope of this paper, but remain an important question for policy officials and regulators.

Regardless of the eventual disposition of the standardization question, consumer decision-making can be assisted through the use of what we call “choice-enabling applications” that allow consumers to enter a minimum amount of information into a search tool and view a limited number of benefit plans that are sorted and ranked based on the consumer’s inputs. These tools are rudimentary today – limited in many respects by the limited “quality” of available plan, cost, network, and formulary data (see Section 1) and effective decision-making tools. Over

time, assuming continued progress along our **Roadmap**, these applications will grow in consumer usability and analytic sophistication, and will become essential to shoppers in the Marketplaces, who will likely face a larger set of choices than the typical employee of a large employer.

In the first part of this section, we profile some of the leading consumer tool makers, providing important context for the data quality discussion above. In the second part of this section, we explore the issue of ensuring that choice-enabling applications are transparent and fair in making recommendations to consumers.

A. Choice-Enabling Applications: A Limited Survey

The current state of choice-enabling apps can be summarized by considering four examples: the consumer tools currently available on Healthcare.gov and those available from the three winners of the 2015 Robert Wood Johnson Foundation Plan Choice Challenge, which recognized “best in class” consumer tools for helping consumers compare health plan cost-sharing features and choose the best plan: Consumer Checkbook, Stride Health and Clear Health Analytics.

Taken together, the four case studies illuminate the opportunities, challenges and future growth potential for consumer tools to help guide insurance “shopping” for everyone from the young and healthy person who expects no doctor visits in a given year to the older consumer with two or three chronic conditions. As described in Section 1, developers of choice-enabling applications face a range of challenges in developing and refining their tools, including:

- **Obtaining Timely and Reliable**

Product Data: As discussed in detail above, application developers need *timely*, *accurate*, and *process-able* data on approved products with enough lead time to incorporate the data into consumer tools before the products are offered for sale. Until this is standard regulator practice, tool makers will use a variety of suboptimal strategies, including “scraping” data websites and purchasing data from third parties, to fill out their data sets. Even in the best case, these approaches have inherent *accessibility* and *completeness* limitations that will inhibit development of choice-enabling applications.

- **Incorporating Claims-Based Data:** Proprietary data sets are available for purchase, and CMS has augmented these databases with Medicare claims data. States could be similarly helpful if they developed and made all payer claims databases (APCDs) publicly available in usable formats.

- **Balancing Privacy and Personalization:** Consumers cannot get individualized information about their options without sharing their preferences and health histories, requiring tool makers to ask for enough but not too much information. Over time, consumers will have data-sharing options that will pit privacy concerns against individualized service. One solution will be to *give consumers a variety of options*.

- **Enabling Consumer Control over Recommendations:** Some consumers will want to see more plan choices than others, but all will prefer some guidance on filtering and sorting plans. When guidance becomes steering will be a delicate question, especially for public Marketplaces that may be constrained in how much “guidance” they can provide.

- **Enabling Mobile Applications:** Turning a design concept into functioning technology will always be a challenge, as shown by the slow emergence of mobile apps despite the rapidly growing reliance on mobile devices.

The healthcare market for consumer choice-enabling applications tools is developing quickly, with stakeholders pursuing differing visions about what consumers most value in search tools. This competition will be further highlighted in an additional Robert Wood Johnson Foundation contest in 2016 on provider search.⁹ It may be that certain best practices will emerge and become the de facto market-determined “price of admission” for all application developers, with continued tension between standardization and innovation.

Below, we profile four approaches to provide a window into the emerging market for choice-enabling applications; other approaches exist, and our choices are not meant to endorse one or another approach. Rather, by describing these as illustrative examples, we hope to provide important context for the **Roadmap** recommendations in Section 1 with respect to quality data, as defined above, and the continued emergence

of consumer-centric choice-enabling applications.

The logo for HealthCare.gov, featuring the text "HealthCare.gov" in a blue sans-serif font. The word "Health" is in a lighter blue, "Care" is in a darker blue, and ".gov" is in a medium blue. The logo is set against a white background within a yellow-bordered box.

- Tool shows premium and total cost of care (new this year)
- Ability to search plans by preferred providers and drugs
- Scheduled to add quality ratings for next open enrollment period

Healthcare.gov. The 2016 federal website’s choice-enabling tools have improved significantly from the first open enrollment period (OEP). Specifically, Healthcare.gov rolled out several new tools for the third OEP, including a total cost-of-care calculation, provider search, and formulary search. Consumers can input information about preferred providers and drugs they take, and can rate their health status on a three-point scale, but cannot enter health conditions. Plan comparisons show both premiums and estimated total cost of care. There are no measures of network strength, but as noted above, the recent CMS payment notice¹⁰ instituted voluntary standard plan

designs for 2017. Healthcare.gov provides less functionality with respect to formularies than its corresponding Medicare Part D website, but can be expected to improve as the Part D website has over the years. One area of improvement is that quality ratings are scheduled to be available on Healthcare.gov for the 2017 OEP. Plans will submit data on 43 measures that address areas of clinical quality management, enrollees' experience and plan efficiency, affordability and management, and CMS will use these data to calculate a global rating using a 5-star rating for each QHP.¹¹



- Displays all plan options in a scroll
- Sortable by total cost of care
- Can input providers and health status on five-point scale
- Considering formulary search in future
- Provides quality scores as separate variable in plan comparisons

Consumers' Checkbook (checkbook.org). Checkbook has been available to help federal employees sort out more than 250 plan choices over the last 36 years, beginning as a booklet and evolving into a web-based approach. Checkbook also hosts a tool for five public Marketplaces. Distinguishing features are that the tool presents all available plans in a scroll by total cost – premium plus out of pocket (the default sort), cost in high-cost year (to highlight the risk factor in insurance), quality score (can be personalized), preferred doctors, and network size. Consumers can input providers, planned major procedures, and health status on a five-point scale. Cost estimates are based on services, products, and drugs for populations like the user (including unexpected events). Checkbook plans to add a formulary search tool.



- Provides single recommendation with care and cost forecast
- Screen shows two alternatives to recommendation
- Advanced features for viewing various cost scenarios
- Can input providers, drugs, and health conditions
- Quality embedded in tool

Stride Health (stridehealth.com).

Stride is a California start-up that is a registered web broker licensed in all 50 states. Stride has close working relationships with Uber and other “new economy” companies that assist independent contractors with the purchase of individual insurance. Distinguishing features are that the tool is designed for mobile-first use; makes a single recommendation, with a personal care and cost forecast; and offers two additional options at the bottom of the recommendation screen. Consumers can input their providers, drugs, and certain leading conditions. Plan comparisons show premium

and total cost of care, with the ability to compare and sort plans on multiple cost scenarios. Quality is incorporated into the proprietary plan selection tool, but is not a sorting option at this time.



- Advanced prediction of total cost of care based on proprietary tool
- Presents three top plans based on cost, doctors, network and formulary
- Can input providers, drugs, and health status on a 5-point scale
- Considering quality information in future

Clear Health Analytics

(clearhealthanalytics.com).

Clear Health Analytics is a start-up company specializing in data analytics that aims to be first in class in predicting total cost of care. The company works with Enroll America and its consumer assisters in providing its tool to prospective enrollees in Healthcare.gov. The company focuses on applying sophisticated analytics to large claims databases to do state-of-the-art predictive modeling.

Key Elements for Consumer Tool Development:

- What information must the consumer provide before she can receive a premium calculation? (e.g., zip code, age, family composition, tobacco use)
- What optional questions are asked up front? (e.g., questions about health status and health conditions for calculating cost are utilization)
- Are there questions about preferred providers and drugs?
- How do plans first appear to consumers on their screens and how explicit and advanced are the sorting principles?
- Do all plans appear in a scroll or a subset of selected plans?
- What alternative sorting options are available?
- What other tools are available? (e.g., tools for “someone with my condition”)

Its ranking and sorting process falls between Checkbook and Stride in showing three plans as the default presentation.

Consumers can input providers and drugs, as well as rank their health status, and the company is considering whether and how to incorporate a quality factor into its tool.

B. An Emerging Regulatory Framework to Support Choice

The examples above are a subset of emerging market choice-enabling applications. From a regulatory standpoint, the growth of these applications will present a set of challenges, depending on how they are deployed in the Marketplace

environment. In some cases, the applications are or may become embedded in the Marketplace website or be integrally linked to the actual enrollment process. Alternatively, the applications are or may exist outside of the Marketplace, and may allow the consumer to assess his or her range of choices, and to reach a tentative decision, but require subsidy-eligible consumers to leave the choice-enabling application and make their actual enrollment decision on the Marketplace’s website. Increasingly, we expect to see hybrids emerge, much as the airline and hotel choice/reservation systems have evolved, where choice-enabling

applications are linked to some – but not all – of the available airlines or hotel chains.

Specifically, we expect the continued evolution of the market for choice-enabling applications to resemble this hybrid model, with all Marketplaces embedding at least one customized choice-enabling application into their publicly sanctioned websites, and each Marketplace making its own decision about whether, and on what terms, to allow stand-alone applications to link automatically to eligibility and enrollment systems.

Regulators will need to address the issues of disclosure and transparency in each case; consumers using a Marketplace-embedded application will expect that the associated decision-support algorithms are agnostic to plan – a level playing field, as it were, with no plan favored unfairly over another plan. Consumers using a stand-alone choice-enabling application, especially one that is linked to or associated with a Marketplace site, may expect a degree of disclosure if the application’s business model is economically incented to favor one plan over another, or does not have the authority or capacity to display all available plans. These are not new issues; they also occur in the context of

traditional agents and brokers, but web-based marketing does create new wrinkles.

To address these issues, CMS has developed a certification program for web-based entities (WBEs) and has certified more than 40 WBEs that are able to partner with the FFM to offer consumers, including those eligible for tax credits, the WBE’s own unique web-based shopping environment – as long as the WBE meets certain consumer protection standards. The WBE policy offers an example for the kind of standards that could be used to ensure public confidence in the fairness and impartiality of plan choice tools. Similarly, the concerns of some SBMs about that web broker policy illustrate the ongoing tensions over how best to serve consumers.

Under the federal WBE regulation, web brokers can enroll consumers through their own websites only if there are both appropriate connections to the relevant state or federal Marketplace and if the web broker signs an agreement and abides by the following consumer protections:

- Registers with the Exchange and receives training in the range of QHP options;
- Complies with the Exchange’s privacy and security standards;

- Complies with state laws, including laws related to confidentiality and conflicts of interest;
- Meets all standards for disclosure and display of QHP information;
- Provides consumers with the ability to view all QHPs offered through the Exchange and displays all QHP data provided by the Exchange;
- Provides consumers with the ability to withdraw from the process and use the Exchange website instead at any time; and
- Maintains electronic records for audit purpose for at least 10 years.

The FFM has implemented the WBE policy for the 38 FFM states, and there are a number of WBEs actively enrolling consumers in subsidized and unsubsidized coverage. However, many WBEs are in a wait-and-see mode, partly because clunky technology has impeded information transfer between WBE sites and the FFM. Nevertheless, the federal policy offers one approach to how Marketplaces can expand access to consumer tools that are available off-Marketplace while protecting privacy, security, and consumer choice. Notably, while the policy originally applied only to web brokers who displayed all

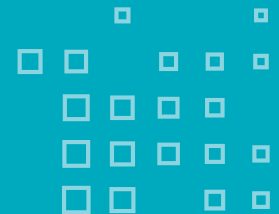
plans, the policy has since been adapted to cover insurers who display only their own plans, with a disclaimer that informs the consumer of their right to view all plans on Healthcare.gov. None of the SBMs have adopted the WBE policy to date,¹² though several have considered the federal “any willing WBE” policy or a hybrid version that would involve partnerships with a select group of WBEs based on their meeting partnership requirements such as co-

branded advertising. In recent comments, Covered California proposed that the federal policy be modified to incorporate more stringent standards for WBEs to ensure that they provide a user experience that more closely comports with the experience on a public Marketplace in terms of telephone support and other services. As app developers continue to refine their tools, we can expect ongoing debates about exactly what standards they should be held to in how

they present information and facilitate or “guide” consumers through the shopping experience. It is likely that the individual market outside the public Marketplaces will see the widest variety of consumer tools, with employers, private exchanges, carrier websites (sometimes called “single carrier private exchanges”), and public Marketplaces exercising more control over what tools are available to individuals on their websites.

Section 3

Enhancing Consumer Health Literacy



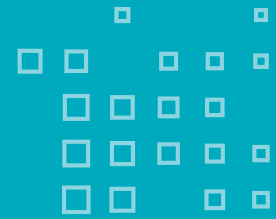
Consumers using Marketplace tools will have a wide array of preferences for the tools they might find helpful. Looking back to the four users profiled in the introduction, consumers like Carlos may just want a quick way to select a health plan, and may not be interested in the nuances that users like Jasmine and Bob will want. Other consumers like Shoshana may be less concerned with speed and more concerned about requests for personal information and may choose not to continue on a site that asks

too many health questions. For the public Marketplaces in particular, tools should be designed to make it simple for consumers to shop anonymously and go straight to picking a plan if they prefer not to answer nonessential questions. Effective and successful choice-enabling applications will need to balance simplicity and consumer education, as well as make clear when questions must be answered and when they are optional for those who want to spend more time providing

information that will lead to more individualized decision support.¹³ As tools grow more sophisticated, we recommend a robust education campaign to educate consumers on the capacities and limitations of consumer tools. It also will be important for Marketplaces to continuously improve the consumer experience with new innovations.

Section 4

Recommendations



Manatt offers four recommendations for achieving the goals of the Roadmap to Transparency by 2020. By that date, consumers shopping in the Marketplaces should have access to consumer tools that allow them to sort and filter plans by premium, total cost of care (based on predicted utilization), preferred providers, and preferred drugs. As technologies improve, tools should allow consumers to input electronic medical records and data from wearables in a manner that fully protects their privacy, and consumers should also have access to meaningful pricing and quality information on treatment options before making treatment choices.

1. Federal and state regulators should work together to make full data on all Marketplace plans publicly available in machine-readable standardized formats at least 60 days prior to open enrollment each year. All FFM and SBM states should be on this timeline by 2018 to achieve this vision by 2020. The data should meet the six data quality criteria – accurate,

complete, consistent, accessible, process-able and timely – for covered benefits, cost-sharing, premiums, provider directories, and formularies.

Discussion: This will require a number of discrete steps as detailed in Section 1. Federal and state action is necessary because data are collected by both Healthcare.gov (38 states) and the State-Based Marketplaces (12 states plus DC). The current deadline for final submission of plans to Healthcare.gov is late August, which would give consumer tool makers the 60 days they need before open enrollment if HHS released the data in a uniform way at that time. States should be able to meet the same timeline. Some plans may be withdrawn after they are finalized, but tool makers say it is preferable to delete plans than wait for late withdrawal decisions.

2. State insurance regulators, with the assistance of the NAIC, should ensure that the same plan data that are made available

for public Marketplaces are made available in the same machine-readable standardized formats for the rest of the individual and small group market.

Discussion: State insurance regulators are responsible for collecting data and regulating the off-Exchange market. Nationally, the market outside the public Marketplaces is 57% of the individual market and more than 95% of the small group market. Given that all individual market coverage on and off the public Marketplaces is part of a single risk pool, it is not possible to fully understand trends in one sector without having information about the entire individual and small group markets. This makes it imperative that state regulators, who have the off-Marketplace data in the State Electronic Rates and Forms Filing system (SERFF), also release the data publicly. Most states already release some SERFF information but typically not in an aggregated format. Ideally all information for on- and off-Marketplace

plans would be made publicly available at the same time in the same format.

3. HHS and state officials should jointly convene an advisory group of public and private experts to establish best practices and, potentially, regulatory standards for the use of data by choice-enabling applications.

Discussion: Consumer tools are critical and all Marketplaces are wrestling with how best to deploy tools and how to set priorities among competing needs. A coordinated effort to identify, debate, and implement best practices would be helpful, perhaps beginning with a national forum. The advisory group should include tool developers designing similar tools for employees selecting plans in the group market. Regulatory action should be considered to ensure that consumer tools educate without misleading consumers, though it will be critical to preserve a climate of innovation as well.

Research studies, expert panels, and focus groups should be used to determine other salient data points for consumers. As mentioned in the discussion of network issues, there are various factors that may be priorities

to consumers. This is just one area where further analysis should be done to determine the right questions to be answered, as well as identify future data needs that will generate a new set of questions. Consumer reaction to quality star rating is another area that might benefit from more research as the Marketplaces start implementing such rating systems.

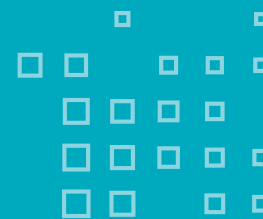
4. State and federal officials should collaborate with private payers to expand access to large claims databases and to pricing and quality data on medical services. State and federal agencies should expand their efforts to provide databases on public programs, including All Payer Claims Databases (APCDs) modelled on the most successful state versions. Insurers, hospitals and others should be encouraged and, where appropriate, required to make pricing and quality information available in real time to enable consumer shopping.¹⁴

Discussion: State and federal regulators can help aggregate and publish claims data in process-able form, but much of the data to determine predictive costs and to

estimate costs of specific services will continue to reside in private databases, making public-private partnerships necessary to achieve transparency. Such efforts are under way, but efforts must be accelerated. Large claims databases are an essential resource for any choice-enabling application to be able to help consumers predict out-of-pocket costs, based either on information that they choose to input themselves, or HIPAA-compliant auto-uploaded data whose use by the choice-enabling application in developing a recommendation is explicitly agreed to by the consumer.

Section 5

Conclusion



Lack of transparency is often cited as a major flaw of the U.S. healthcare system. When it comes to picking the “right” high-value, high-quality plan, the devil is in the details – and the details remain perplexing to many consumers. The consequences of selecting the “wrong” plan are particularly steep for individuals with chronic conditions requiring heavy care utilization. As such, Marketplaces can – and should – do more to ensure all shoppers have highly effective decision-making support tools and the full spectrum of transparent plan information at their fingertips. We are in the thick of the Big Data era, where data of every

shape, size and form are constantly being collected, analyzed and turned into effective solutions. While other industries have been seizing the opportunity to harness transparent data to drive competition and encourage consumers to be savvy shoppers, the health Marketplace remains opaque. Federal and state regulators have the opportunity to transform the Marketplace for the benefit of consumers by making valuable data on health plan options publicly available in ways that encourage the development of sophisticated decision-making support tools.

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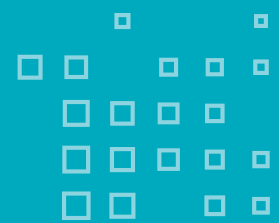
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About Manatt

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Appendix

Predicting Treatment Cost and Enabling Comparison Shopping for Services and Treatments

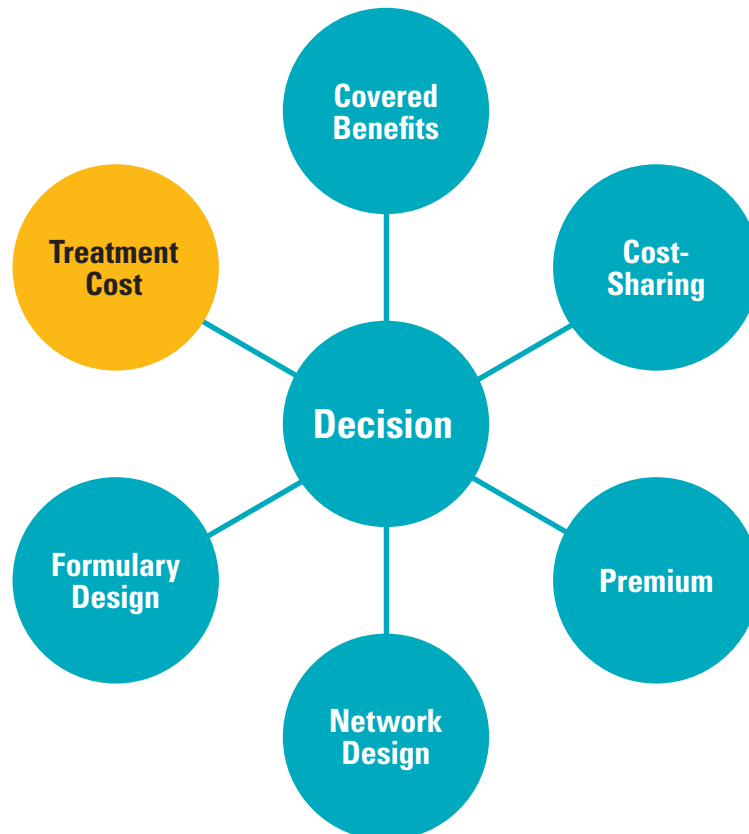


Access to the data described in **Section 1** is a critical first step to enabling consumers to compare plans by characteristics. However, for consumers to choose the “best plan,” “best formulary” and “best network,” they will eventually require decision-support tools to predict individual healthcare needs – and, importantly, *the net patient cost of potential treatments*. In most plan designs, with deductibles and co-payments, the net patient cost is, in part, a function of the billed or contracted fees for a given treatment. In addition, as consumers and patients are increasingly presented with treatment options that vary in risk prognosis, and price, informed decision-making requires close review of accurate data on the costs of treatment alternatives.

Thus, in a consumer-empowered market, patients will need data, information, and applications to help them predict their cost of care – information needed either to choose the best plan or to choose the best course of

treatment. While the factors described in Section 1 are based on data that regulators collect, predicting cost of care requires data that is typically aggregated by insurers but not (yet) collected systematically by state or federal regulators, except for public programs and states that have All Payer Claims Databases

(APCDs). The ideal future would include all states developing APCDs modeled on the most successful states, such as Maine and Utah, supplemented by public release of claims data on public programs at the state and federal levels. A more realistic scenario is that app developers will continue to rely



on private data sets to augment public data sets in order to address proprietary business concerns. In each case, the technical issues of calculating an expected “price” or “cost” of a treatment or service will prove challenging; and the clinical uncertainty around the ultimate course of treatment and its eventual cost may argue against a “point estimate.” Nonetheless, by anticipating consumers’ demand for accurate and timely cost-of-treatment estimates, we can enhance the Roadmap and expand consumers’ access to the right data and information to make the right choice on plan, formulary, network, and treatment.

The first and easier challenge will be the prediction of annual costs by entering a specific benefit or condition and getting estimated annual costs. Last year, Navigators reported that they often would use a paper and pencil to calculate total expected costs for a family under a plan.¹⁵ A calculator that can estimate tailored out-of-pocket costs as a comparison tool is critical for consumers, and some SBMs and the FFM have a version of this today. The FFM allows a user to choose high, medium and low; Connecticut’s website permits consumers to choose from many conditions. These tools

are critical, but they estimate generally the cost of care, and do not differentiate between the cost of care of different providers and treatments.

The tougher challenge will be to serve consumers who want more than an estimate of their total annual costs under a plan, who also want access to information and apps to determine the right provider and the right treatment. So, for example, consumers might want to have an app that shows how much the MRI their provider is recommending will cost or the cost to see a particular endocrinologist. Some consumers will want an app to indicate the cost of knee surgery versus alternative treatments. These apps will be used just as much, perhaps more, after a consumer has chosen a plan as a care management tool. Oregon is implementing a form of this under a 2007 law that requires insurers to make pricing information available on their websites for a set of common services. The information must be available in real time but only for plan members, and the list of services started out small and is slowly being expanded.¹⁶ The ACA includes a requirement similar to the Oregon law that has not been implemented yet.¹⁷ These data and these

apps are probably beyond the Marketplaces for 2020, but as these tools are developed in the private market, experience with them may inform if any should be required in Marketplaces.

For complex services, consumer decision tools will require public and private partnerships, with government releasing more data on public programs and encouraging private parties to do the same so that app developers have broader access to price and claims data that will help them refine their predictive models, and provide pricing data for real-time shopping.

¹ Kaiser Family Foundation. May 12, 2015. "Data Note: How Has the Individual Insurance Market Grown Under the Affordable Care Act?" Available at: <http://kff.org/health-reform/issue-brief/data-note-how-has-the-individual-insurance-market-grown-under-the-affordable-care-act/>

² Kaiser Family Foundation. May 12, 2015. "Data Note: How Has the Individual Insurance Market Grown Under the Affordable Care Act?" Available at: <http://kff.org/health-reform/issue-brief/data-note-how-has-the-individual-insurance-market-grown-under-the-affordable-care-act/>

³ HHS. March 8, 2016. *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017* [CMS-9937-F]. Available at: <https://www.federalregister.gov/articles/2016/03/08/2016-04439/patient-protection-and-affordable-care-act-benefit-and-payment-parameters>

⁴ Collins, S., Gunja, M., Doty, et al. (September 2015). "To Enroll or Not to Enroll? Why Many Americans Have Gained Insurance Under the Affordable Care Act While Others Have Not." *The Commonwealth Fund*. Available at: <http://www.commonwealthfund.org/publications/issue-briefs/2015/sep/to-enroll-or-not-to-enroll>

⁵ National Association of Insurance Commissioners (October 12, 2015). *Health Benefit Plan Network Access and Adequacy Model Act* [#74]. Available at: <http://www.naic.org/store/free/MDL-74.pdf>

⁶ HHS. March 8, 2016. *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017* [CMS-9937-F]. Available at: <https://www.federalregister.gov/articles/2016/03/08/2016-04439/patient-protection-and-affordable-care-act-benefit-and-payment-parameters>

⁷ Kaiser Family Foundation. January 28, 2016. *Kaiser Health Tracking Poll: January 2016*. Available at: <http://kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-january-2016/>

⁸ DuGoff et al. January 26, 2016. "Put the 'Network' in Measures of Network Adequacy," *Health Affairs Blog*. Available at: <http://healthaffairs.org/blog/2016/01/26/put-the-network-in-measures-of-network-adequacy/>

⁹ RWJF & ProPublica. "Finding the Right Provider Challenge." See: <http://www.health2con.com/devchallenge/rwjf-and-propublicas-personalized-provider-challenge/>

¹⁰ HHS. March 8, 2016. *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017* [CMS-9937-F]. Available at: <https://www.federalregister.gov/articles/2016/03/08/2016-04439/patient-protection-and-affordable-care-act-benefit-and-payment-parameters>

¹¹ Health Insurance Marketplace, Quality Rating System: Overview of 2016 Requirements for QHP Issuers, November 2015.

¹² Ario, J., Garciamonde, A., & Kingsdale, J. June, 2015. "Understanding the Potential Role Web Brokers Can Play in State-Based Marketplaces." *Robert Wood Johnson Foundation Issue Brief*. Available at: <http://statenetwork.org/wp-content/uploads/2014/11/State-Network-Manatt-Wakely-Web-Brokers-June-2014.pdf>

¹³ See, e.g., Covered California's Shop and Compare website: <https://www.coveredca.com/shopandcompare/2015/>

¹⁴ The Supreme Court's decision on March 1, 2016 will limit the value of APCDs by impeding state collection of self-insured data. One solution, suggested by the Court, would be for federal government to authorize data collection in a uniform way.

¹⁵ National Partnership for Women & Families. June, 2015. "Lessons from the Frontlines: Strategies for Supporting Informed Consumer Decision-Making in the Health Insurance Marketplace." Available at: http://www.nationalpartnership.org/research-library/health-care/lessons_from_the_frontlines_strategies_for_supporting_informed_consumer_decisionmaking_in_the_health_insurance_marketplace_june2015.pdf

¹⁶ HB 2213 B. Available at: <https://olis.leg.state.or.us/liz/2007R1/Downloads/MeasureDocument/HB2213>

¹⁷ Section 1311(e)(3)(C) of the ACA. The requirement is for real-time shopping information: The Exchange shall require health plans seeking certification as qualified health plans to permit individuals to learn the amount of cost-sharing (including deductibles, co-payments, and coinsurance) under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon the request of the individual. At a minimum, such information shall be made available to such individual through an Internet website and such other means for individuals without access to the Internet.

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