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Research Insights

Choice and Decision-Making in a Health Insurance Exchange: What Does Research and Experience Tell Us?

Summary

Health insurance exchanges are a key component of health insurance coverage expansion in the Patient Protection and Affordable Care Act (ACA). States are at different stages in their determinations about how to structure their Exchanges and how key functions of the Exchanges will be accomplished, but all face common questions such as: how to promote participation in the Exchanges; how to ensure that people who are eligible for financial assistance apply; how to provide useful information about insurance products; and how to help businesses and consumers make informed choices about health insurance. Given that a diverse population is expected to use the Exchanges, it is important to consider how answers to these questions might differ depending on the group the state is trying to reach.

This paper summarizes key points from an expert panel AcademyHealth convened to identify how the knowledge from existing research can inform policy development in this area. One body of research comes from the field of behavioral economics and other fields that examine the process of consumer choice, generating insights that can help inform policies related to the design, implementation, and regulation of Exchanges. Another body of research focuses on prior experience with the Medicare and Medicaid programs as well as with choice among private insurance options. Such studies provide concrete examples of ways to facilitate or impede choice in the health insurance market.

Through this research we know that encouraging people to use the Exchanges—to sign up for coverage—is an initial challenge. Later, other challenges emerge, with history showing that choice among health insurance products is difficult for many consumers to navigate. But Exchanges, the technology that they employ, and the Navigators whom they employ to assist consumers represent resources that can help consumers distinguish among health insurance products based on quality. Additional research will be needed as Exchanges are established and begin to operate. Exchanges can be an important source of information about market factors, consumer choices and enrollment dynamics. Thus, it will be helpful if states consider the potential for data collection and use as they design health insurance exchanges.

Overview

Health insurance exchanges are a key component of health insurance coverage expansion in the Patient Protection and Affordable Care Act (ACA). Exchanges are virtual marketplaces where uninsured individuals and small businesses can shop for private health insurance products. The ACA calls for the creation of Exchanges in all states by January 2014. The Congressional Budget Office estimates that approximately 24 million consumers will purchase their own coverage through the Exchanges by 2019 and that 81 percent of them will receive subsidies.[1] As of May 2012, some 49 states and the District of Columbia had planning grants; 34 of them also applied for and received grants to establish Exchanges.[2]

Exchanges provide a single point of contact where those seeking insurance can determine which insurance programs they qualify for (Medicaid, CHIP, Exchange-based coverage), learn about plans available to them, and both sign up to get coverage through the Exchange and to choose a particular health plan. Those qualifying for exchange coverage will learn whether they qualify for financial assistance – premium tax credits and cost-sharing reductions – to

purchase insurance. Exchanges also are charged with providing web-based guidance to help consumers compare health insurance products. For small businesses, Exchanges will also help employers select health insurance plans that their employees can then choose. Finally, Exchanges are expected to award grants to "Navigators," organizations or individuals who will help consumers and employers learn about and enroll in qualified health plans. Three types of Exchanges are envisioned: state-operated Exchanges, partnership Exchanges established by the federal government with some operational functions performed by states, and fully federally-facilitated Exchanges.

In June 2012, AcademyHealth's *Research Insights* project convened a meeting that brought leading academic researchers together with policy audiences to discuss what research and experience indicates about how best to structure effective and efficient consumer choice in the Exchanges. Researchers familiar with behavioral economics and related fields presented insights on the process of consumer choice. The meeting featured relevant research drawn from experiences with Medicare Part D, Medicare Advantage, Medicaid managed care, and the Federal Employees Health Benefit Program. Attendees were asked to focus on key research and policy questions about promoting consumer choice:

1. How can effective and efficient consumer choice in the Exchanges be achieved?
2. What is known about the best ways to ensure all consumers have adequate information upon which to make their choices?
3. What additional research and monitoring is needed once Exchanges are implemented?

During the meeting, issues related to other Exchange functions – particularly the initial application process – were also raised and discussed.

This brief presents a summary of the June meeting. Because the session was "off-the-record," this document is intended to convey the general content of the meeting without attributing specific comments to particular participants. The discussion was informed by existing research, though neither it nor this brief incorporate a systematic review of the literature on consumer choice. We incorporate a bibliography of important current literature on the topic at the end of the brief, a subset of which is specifically referenced in the text.

Promoting Participation In Exchanges

The meeting was convened primarily to discuss choice and decision-making in health insurance exchanges, but several attendees noted that a more immediate concern is ensuring that people take the initial step of participating in the Exchanges. Based on past experience and current activity, discussants say that this is not a simple task. Most people, with the exception of the chronically ill, do not have an immediate need for health insurance. That reality, combined with the finding from behavioral economics that people prefer to remain with the status quo, are reasons that people may not apply. Meeting participants underscored the importance of a single, streamlined process for both applying for insurance through the Exchange and then choosing a particular plan since a two-step process would create an additional opportunity for consumers not to pursue coverage.

Facilitating enrollment

Exchanges may want to look to practices that have been successful in facilitating enrollment for other programs. In CHIP, one of the more successful enrollment strategies is to "pre-fill" application forms with information that is readily available to the program, reducing burden on applicants. One meeting participant suggested that applicants be asked for permission to check with the Internal Revenue Service to verify income both for the initial application and at renewal.

The strategy of auto-enrolling people in programs or plans, but letting them opt out was also cited. Employers, for example, have achieved high enrollment rates for retirement plans using this approach. In Louisiana, the Medicaid program has been successful at automatically enrolling children who receive Supplemental Nutrition Assistance Program (SNAP) benefits in Medicaid and re-enrolling them based on data available from other state programs. The Medicare Part D program auto-assigns beneficiaries who are dually eligible for Medicare and Medicaid to drug plans if they do not choose one on their own.

Several people pointed out that the concept of default enrollment is more complicated for Exchanges, most notably because choice is likely to have a financial cost for enrollees since all contribute to premiums, even if subsidized. And, it would be difficult administratively to assign people to plans in a system where all plans require premium payments. One possibility would be to enroll people provisionally and not provide coverage through the plan until they take the proactive step of paying a premium. To avoid adverse selection, it would be necessary to limit the period when insurance could start. Administrative costs and potential confusion are associated with that approach, however.

Differences among plans also add complexity. In the Part D program, low-income beneficiaries are randomly assigned to prescription drug plans; generally, their current drug regimens are not considered. If Exchanges were to assign enrollees, they would have to consider whether to use enrollment criteria such as matching people with plans whose networks include their current providers and, if so, where, if anywhere, data can be obtained to allow such a matching process. Other factors such as quality measures might also be considered in making assignments. Another aspect of enrollment dynamics that meeting participants touched on is that failure to pay premiums is a big reason for leaving plans and Exchanges. Much will depend on

what policies Exchanges adopt. For example: Is there a grace period for late premium payment? When are people disenrolled? Who pays for services that people receive during that time period? Once people are disenrolled, how long must they wait before they can re-enroll? Is the consumer responsible for the payment? If not, will consumers refrain from paying premiums for a time? Practical steps that Exchanges can take such as accepting automatic payments to facilitate payment and reduce late payments were also discussed.

Similarly, income volatility among the lower-income population "on the cusp" of eligibility for Medicaid or private health insurance subsidies complicates plan and Exchange enrollment. Exchanges can require that all plans offer coverage to all comers so that once consumers choose a plan they do not see a change in coverage when their eligibility status changes. They will also have to decide who will sort out payment issues. People who receive subsidies but have an increase in income over the course of the year are at risk of having to pay the IRS at the end of the year. Exchanges have to let people know about this program feature, which also adds complexity.

Understanding segments of the "Exchange population"

A recurring theme throughout the day's discussion is that understanding of the different segments of the population is necessary in order to reach people effectively and encourage them to apply and choose. Several people emphasized the importance of having a robust group with varied health care needs participate in the Exchanges. To that end, some stressed the importance of ensuring that healthy people do not get frustrated and give up. Meeting participants spoke about the "young and healthy," "the passive or skeptical," and the "indestructibles or invincibles" as groups that are particularly difficult to reach. Strategies that have been used to engage more reluctant populations were described. One participant noted that Massachusetts conducted a Mother's Day campaign to encourage young men to get enrolled to please their mothers. The state also recruited the Red Sox to help publicize its health reform program. In Baltimore, a campaign to reach young black men was conducted through barbershops.

A related issue is how to promote uptake among the population that is eligible for Medicaid and CHIP since many who are currently eligible for these programs do not participate in them. Similarly, a significant portion of those eligible for the Medicare Part D Low-Income Subsidy (LIS) program have not applied for this benefit resulting in them needlessly paying Part D premiums.[3] It will be important to be sure that consumers know about expansions in Medicaid eligibility and about the availability of premium tax credits and cost-sharing reductions. The June 2012 Supreme Court ruling on the ACA's Medicaid expansion, which occurred subsequent to this meeting, gives states more flexibility in making decisions about who they will cover under Medicaid. In states that chooses not to expand the program, a group of people whose incomes are not low enough to qualify for Medicaid, but are too low to qualify for subsidies may be left without coverage options because of the way the law is written. Under these circumstances, coverage options would be more difficult for Exchanges to explain and for consumers to understand than if the Medicaid expansions occur. Experience when the Medicare Part D coverage gap, also known as the "donut hole," was introduced suggests that there could be considerable confusion about program design. Explaining to people who fall between the eligibility categories for Medicaid and subsidies – many of who have income that fluctuates – that they should re-apply for assistance as their financial circumstances either improve or worsen will pose another challenge for Exchanges in those states.

Consumer Choice Within Exchanges

As noted earlier, once consumers apply, they still face the challenge of choosing an insurance product. Meeting participants noted that people dread shopping for health insurance for a variety of reasons: they don't understand the product; they realize there are great financial and health implications for their families; and they may not trust insurers. Thus, an issue of central importance is how to effectively engage consumers in choosing a product. To help answer this question, it is important to understand what drives decisions about health insurance and how much choice is desirable.

Factors that drive decisions about health insurance

Past research suggests that consumers value certain features of health insurance. For example, they have a strong preference and willingness to pay for an open network that will allow them to choose the providers they want to see. But other factors are important also. Research that examined Medicare beneficiaries' priorities in choosing plans shows that the most important priority is whether they can get the care they need when they are sick. Other factors are the costs and benefits associated with the plans and whether they can choose their personal doctor or self-refer to a specialist. The ability to get care away from home and limited paperwork are also attractive.[4]

Meeting participants agreed that different segments of the population using the Exchanges will have different priorities and that factors such as age, health status, pre-existing medical conditions, and previous experience with health care systems will affect consumers' priorities. They noted, for example, that younger healthy people might choose plans based primarily on price or they may find extra benefits such as wellness programs, or dental or vision benefits enticing. People with medical conditions may be more interested in staying with their current providers or finding plans with formularies that provide good coverage for their prescription drugs. Experience from the Part D program bears this out, though consumers' needs for prescription drug coverage are somewhat more predictable than for a broader range of health care services.

There are particular concerns about achieving continuity of care for the chronically ill who do not currently qualify for Medicaid and have been getting care from safety net providers. The ACA offers some protection by requiring that qualified health plans include a sufficient number of "essential community providers" that serve low-income and medically underserved populations in their networks. Meeting participants suggested that additional protections may be needed.

One meeting participant observed that past experience may make consumers cautious. Those who have had experience with market instability may tend to choose plans that they perceive as being more reliably available in the long run because they have roots in the community. Some Medicare beneficiaries have become more comfortable evaluating and choosing plans because of their Part D experience. One participant suggested that beneficiaries' increased familiarity with the plan comparison process may make them more receptive to the idea of comparing Medicare Advantage plans and that may be a factor related to increased enrollment in Medicare Advantage plans. There was a sense that consumers could come to value Exchanges as they use them and that Exchanges might have to evolve as consumers become more familiar with choosing and using plans.

Different considerations for Exchanges

Several speakers noted that what was true in the past might not be entirely relevant for the future because the people who are expected to enroll through the Exchanges differ as a group from those who have purchased insurance in the past. Many have been uninsured. They may not have used health care services for a number of years or may not have a usual provider and therefore may be more willing to accept a plan with a closed network. Other aspects of the plans may be more important to them.

Provisions in the ACA will change the health insurance market and therefore, certain factors that have been the basis for making choices about insurance products in the past will not be as relevant in the future. With requirements such as guaranteed issue, rate restrictions, maximum cost sharing, and standard benefits, plans should be more similar than in the current market. Therefore, it is important to think about how to help consumers differentiate among plans on other dimensions.

Quality considerations

According to one presenter, past research shows that consumers have been reluctant to enroll in lower-cost, high-quality alternatives, when doing so requires them to switch doctors. When consumers were given hypothetical choices of plans, even reported differences in quality were not sufficient to overcome the tendency to choose plans that allow enrollees the flexibility to choose their own provider except when the quality differences were very large. But meeting participants said they think consumers may be more interested in considering factors related to quality now. They suggest that one way to encourage this is to feature information about quality as prominently as information about cost in describing plans. They note that standard quality measures developed for reporting on managed care plans — HEDIS (Health Care Effectiveness and Data Information Set) and CAHPS (Consumer Assessment of Health Care Providers and Systems) – have been available to consumers in Massachusetts and to Medicare beneficiaries considering Medicare Advantage and Part D plans.

The ACA places a great deal of emphasis on quality. One speaker noted that HHS has an obligation to develop new quality measures. Several people suggested measures that Exchanges could develop to help consumers choose. One person said that perhaps the most important criterion to measure is how well plans take care of people when they are sick. Aspects of plan administration such as how long people wait on the phone for assistance from the plan or how quickly and easily claims are paid were also cited, as were factors such as the stability of enrollment and reasons for disenrollment. A composite measure that provides information about complaints, grievances, or appeals associated with the plans was also mentioned. Discussants noted that Exchanges may provide an opportunity for consumers to become more familiar with the quality of health providers in each plan, but cautioned that it will be necessary to ensure that information about providers is accurate. The standards that Exchanges use to certify qualified health plans can also have an impact on the quality of the plans offered.

The concept of "teachable moments" was introduced in the discussion with the suggestion that certain life events – marriage, divorce, changes in employment – provide an opportunity to educate consumers about health insurance. For example, unemployment offices have been a logical place to help people understand COBRA benefits.[5] One discussant observed that the advent of Exchanges may provide an opportunity to get potential enrollees to think about the quality of what is inside the plan — the doctors and hospitals. Exchanges could feature and link to other public resources about the quality of doctors and hospitals that exist in some states.

A less immediate, but still important issue raised by meeting participants is whether consumers will switch plans. Enrollees will have the opportunity to re-evaluate their choices from year to year. Researchers note that the same status quo bias that keeps people from opting out of programs also affects decisions about plan switching. This "stickiness" is evidenced in the Part D program. Between 2011 and 2012, premiums for one large prescription drug plan increased while another decreased substantially, yet enrollment for both increased slightly. Among subsidized Part D beneficiaries, 5 to 10 percent are reassigned by CMS to new lower-premium plans each year, but among those who are not reassigned because they have made choices on their own in the past, 10 to 20 percent do not switch to lower premium plans and therefore pay premiums unnecessarily.

How much choice is desirable?

With many choices, especially when each option has multiple factors to consider, people may have a harder time choosing than if fewer choices were available. The literature suggests that as a result of "choice overload," people may have "decision fatigue," have a harder time choosing, perform worse if they choose, and be less satisfied with the choices they make. There is evidence from research related to the Part D program of failure to make optimal choices. Older participants and those with more choices failed to identify low-cost plans. Beneficiaries report that they are happier when more choices are offered, but they have more difficulty in making choices. The need to make a choice can keep people from moving forward. Weighing multiple factors, fear of error, sense of inadequacy can lead to procrastination or avoidance. In a study of Medicaid enrollment in California counties with and without health plan options, enrollment within the first month of eligibility was significantly higher in counties with just one option than in counties with multiple options.[6]

A key question is how to structure an effective market and a practical question is how many plans to offer. Policymakers must balance the need for consumer choice with the desire to protect consumers from suboptimal choices or an overabundance of plans that do not fit consumers' needs. At the same time, plans that want to be included in Exchanges advocate for more choices. One participant reported that Utah currently operates an exchange for small employers that has more than 300 plan choices, but most of them are not being used.

Meeting participants agreed that there should be significant differences among plans. If plans do not vary in substantive ways, choice just clutters up the market without adding value for consumers. This happened in Medicare Advantage, leading CMS to require meaningful differences among plans, a policy change that ultimately led to a reduction in the numbers of Medicare Advantage plans and Medicare Part D prescription drug plans in recent years. Some suggested that one way to limit the number of plans and ensure that high quality plans participate in the Exchanges is to require that they go through an accreditation process, such as the NCQA (National Committee for Quality Assurance) process.

Helping People Choose

Meeting participants discussed both Web-based and more personal types of assistance for consumers.

Methods to help narrow choices

Given that consumers are reluctant to make choices about health insurance and therefore may be easily discouraged, one recommendation is to use a tool that gives immediate feedback so that consumers can choose a plan quickly and there is a sense of progress or momentum to keep the process going. Consumers may benefit from tools that use choice architecture to help narrow choices.[7] One participant explained the method by describing drop-down screens that appear on commercial websites after initial choices are made. The idea is that narrowing the number of choices in a logical way will assist in decision-making.

Consumers could be given the opportunity, for example, to indicate first what features of health insurance products they care most about – such as cost or whether a particular physician is in plan networks – and then to view other features for a smaller group of plans that pass these filters. The website www.healthcare.gov currently includes sorting features that allow consumers to rank all of the health plan choices based on a variety of criteria. Other filters allow consumers to view just a subset of plans sharing common features. Another approach, delegated choice, could allow consumers to specify key factors – such as premium range, current physician, regular prescriptions – and have the Exchange suggest a plan or set of plans to choose from. In both cases, information that the consumer provides is used to narrow down the choices to a shorter list that may better meet the consumer's needs. One meeting participant pointed out that since people do care a great deal about being able to keep their doctors, the accuracy and completeness of doctor directories will be important during the enrollment process. One recommended search strategy is to allow users to put in a doctor's name and see all the plans that that person belongs to rather than have to hunt through multiple directories looking for a particular doctor.

Some were concerned, however, that if consumers are not savvy about insurance products, they may not understand or be well informed about what the most important feature for them should be and therefore may rule out certain features too early. For example, a

consumer may filter first based on a preference for a certain physician, but that could eliminate a range of low-cost plans. Or, if cost is the first criterion, complete information on quality may not be available and plans with other important features, such as high-quality, may be eliminated early. Others were cautious about the "big brother" aspect of tools that narrow choices too early, noting that they are not comfortable steering people based on a pre-conceived notion of what tool designers think consumers should be choosing. At least one state has convened stakeholders to help define filters.

Panelists pointed out that some large private firms and public employers have been offering a range of health insurance choices for a long time, which could mean that it may not be necessary to narrow choices. Similarly, consumers are asked to make other choices such as purchasing a car that have many features and a variety of people are comfortable looking for the information and making the choices. But others argue that the level of uncertainty associated with the purchase of health insurance makes it a different kind of calculation. Further, car purchases have a significant number of consumers "aides" that are trusted and standardized that help consumers navigate their choices – assistance that is currently missing in health insurance shopping.

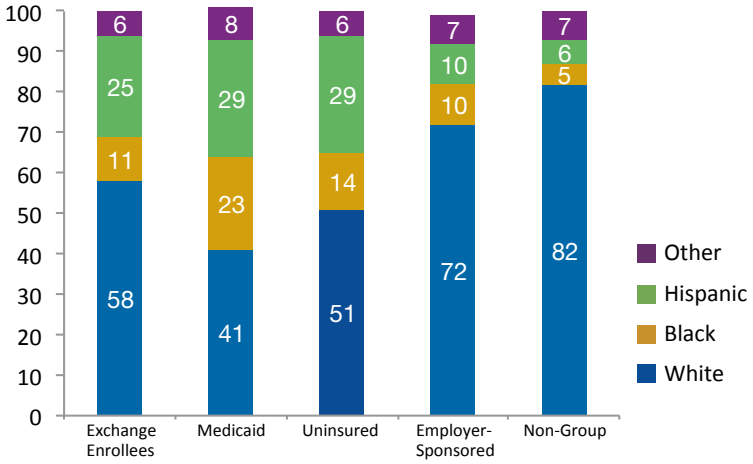
Other assistance for decision-making

Discussants emphasized that Web-based support is valuable, but cannot be the only channel available to consumers. As one noted, the option of live consumer assistance is critical. When consumers have questions, they should be able to get someone knowledgeable on the phone. Experience with the Medicare Part D program and with the Massachusetts health insurance program indicates that Exchanges should plan for very long calls. Having people available by phone outside of normal business hours is also recommended.

Some consumers will need individual assistance including face-to-face counseling that is culturally competent. Research and experience indicate that counseling is most effective when provided by a trusted source. The ACA requires that Exchanges award grants to "Navigators." To date, 34 states and the District of Columbia have received Exchange Establishment grants, which can be used for start-up activities such as consumer outreach to raise awareness of the Exchanges and to help plan for navigation activities in the Exchanges. CMS plans to award Exchange Establishment grants through 2014.

The Consumer Assistance Program, established in the Affordable Care Act, is another source of support. In 2010, CMS awarded grants to 38 states. The funds have been used to: help consumers enroll in health coverage; educate consumers about their rights; file complaints and appeals against health plan; and to track consumer

Race and Ethnicity of Projected Health Insurance Exchange Enrollees and Other Coverage Groups



Source: Kaiser Family Foundation, A Profile of Health Insurance Exchange enrollees, March 2011. (Simulation of 2019 Health Insurance Exchange enrollment population using CBO assumptions and the 2007 Medical Expenditure Panel Survey.)

complaints to help identify problems and strengthen enforcement. Additional funds were awarded in 2012 to 15 of the 38 states.[8] A funding announcement released on June 7, 2012 allows all states to apply for new grants for the coming year.[9]

Participants noted that it may be wise to work with multiple sources or intermediaries that are trusted by different segments of the population. Exchanges can establish more than one Navigator program. Experience with Medicare Advantage indicates that demographics, health status, vision and hearing capacity, cognitive capacity, literacy level, language, use of the Internet, and cultural background are all factors that have been shown to affect choice and support needs. Consumers' perceptions regarding trusted sources can also differ from one region of a state to another.

Projections indicate that Exchange enrollees will be racially and ethnically diverse. Thus, attention to cultural competence is necessary. Past research supports this. For example, research on enrollment dynamics in a Medicaid managed care program showed that stable enrollment was strongly associated with the language spoken by plans' physician panels.[10] An example of a particular population looking to intermediaries comes from Massachusetts where trusted facilitators for the Hispanic community helped the CHIP program achieve a very high take-up rate.

In addition to designated Navigators, others will play a role in counseling consumers. Some meeting participants asked about the potential role of independent brokers, noting that Exchanges will have to work with brokers to attract small businesses. Questions about the role of the employer were also raised, with mixed opinions expressed about whether employees regard employers as trusted sources of accurate, unbiased information about health

insurance. Since many of the employers using the Exchanges have not offered insurance in the past, some suggested that they be of limited assistance.

Experience with both Medicare Advantage and Part D indicates that beneficiaries rely most on informal sources to help them make choices. They tend to consult with physicians, family, and friends. Pharmacists played an important role in counseling beneficiaries at the start of Part D. Some consumers also view AARP as a trusted source of health plan information. Part D relies heavily on SHIPs (state health insurance counseling programs for Medicare), and other community-based organizations. Participants said that accommodations and support for people with disabilities are not common. One meeting participant reported that insurers have set up storefronts to attract customers in some areas and questioned whether consumers can distinguish among insurers, brokers, and counselors.[11]

Meeting participants agreed that regardless of the information or counseling source, extensive training is needed so that people who are approached for help can be responsive to questions about complicated issues. When Part D was introduced and pharmacists and doctors were approached for information or assistance they often did not know how to give advice about the program or did not have the time to do so. A recent survey of insurance brokers found a significant number have information gaps about new requirements and programs under the Affordable Care Act.[12] Therefore, information campaigns that target health professionals will help ensure that they encourage people to enroll and know where to send them for information or assistance.

How To Present Information To Consumers

The manner in which choices about insurance are presented to consumers can have an impact on the choices they make. Therefore, a key question for policymakers is how to ensure that all consumers have adequate information. Another is how to present the information in a user-friendly manner.

Considerations for presentations

Research on consumer comprehension of comparative health care information indicates that simpler presentations, with fewer indicators are more helpful. Simplifying language, even if descriptions of insurance elements are less precise as a result, appears to be more useful to consumers. Some suggested that the use of symbols can help consumers compare insurance plans. Others cautioned that symbols might be misinterpreted and should be tested with consumers prior to using them. For example, several participants noted that consumers may equate dollar signs with quality. Therefore, the use of words rather that symbols was suggested with the caveat that the language must be simple.

There was a plea, though, that presentations not skimp on the basics because some potential users have little knowledge of health insurance. Meeting participants cited instances of consumers not realizing that premium payments were a requirement of program participation or not understanding why they have to pay premiums in months when they do not use services. One person observed that consumers often do not read all of the information that they receive and that this argues for simplicity.

While not disagreeing that simple presentations are desirable, several speakers argued that sufficient detail must be available for consumers who are more familiar with various aspects of health insurance and want to make detailed comparisons among plans. One noted that this is a desirable feature of Web-based presentations. The group agreed that the use of an organizing framework to categorize information is helpful, with the caveat that it is important to consider how much standardization is desirable.

Since a wide variety of people will be using the Exchanges, different types of presentations may be effective for different audiences. Ideally, more than one tool or more than one way to use a tool can match the presentation of information with different users' learning styles. What helps consumers with high numeracy skills may not help those with low skills. Some Exchange users may be looking for quick, simple guidance while others may want to have the option of conducting more in-depth research on their own. The suggestion that consumers should have the option of obtaining information "at a glance," with the ability to dig deeper for more detail was well received by the group.

Some discussants commented that presentations that feature synthesized information, for example that use standard measures (such as "miles per gallon" or "registered nurses per 100 patients") have the advantage of being more easily understood by consumers than raw data would be. Cognitive shortcuts that summarize, highlight, or order information also allow consumers to make comparisons across products more easily than if a variety of measures were used. Meeting participants noted, however, that few standard measures are currently available for health insurance products.

Specific examples, which illustrate the value or potential value of purchasing insurance, may give people a better understanding of benefits and perhaps convince them to enroll. For example, a question that is important to try to answer for consumers is: How much will this plan cost you next year, given your current patterns of health care use? Presentations that provide illustrations about total costs and various cost elements may help consumers understand that they should be looking at more than just premiums. Under the ACA, plans will need to provide such illustrations in all coverage summaries.

Research related to Part D, which involves only one benefit – pre-

scription drug coverage – indicates that participants find the program complicated because of variations in premiums, cost sharing, and formularies as well as the potential to choose from at least 25 Prescription Drug Plans per region.

Strong feedback from consumers in at least one state argues for having the Exchange websites look more like sites for employer-sponsored coverage than for Medicaid. Sentiment from the meeting was that employer-like websites are likely to appear more professional and inviting because employers have had more experience in this realm. Insurers also have a stake in the design of the sites. There were questions about how consumers would react to certain terms such as HMO or PPO, whether the terms are understandable, and whether they carry bias. One discussant observed that insurers are interested in how they will be listed on the sites and noted that for some groups – healthy consumers – they might want to appear at the top of the list, but for other groups, they might prefer to be less prominent. Another noted that sites will have to be flexible in some states to accommodate a different selection of plans in different regions.

Meeting participants stressed the need to prepare information for consumers who speak languages other than English and who have different levels of health literacy. Two websites were recommended for Exchange planners. Usability.gov is a federal resource on usability and readability. LEP.gov is a website sponsored by the Federal Interagency Working Group on Limited English Proficiency.

Meeting participants also discussed channels to provide information about the availability of insurance coverage and differences among insurance plans, with the awareness that different methods are needed to reach consumers of different types. Therefore, use of a variety of media options was recommended. For example, the use of Twitter and Facebook was recommended along with a process for people who do not have or do not use the Internet.

Involving a variety of people in the design phase

The group agreed that all types of users should be involved in the design and test phases for messages and tools. Also, meeting participants pointed out that large employers have offered insurance choices for a long time, as has the federal government for its employees. Therefore, it is logical to include people who have experience facilitating choice for groups in discussions for the Exchanges.

Several participants stressed that testing messages and presentations is essential. As they noted, "We don't know what we don't know" and therefore, understanding how tools can be most effective before they are launched will help ensure success. Tests should examine not only what consumers report that they understand, but also include an objective measure since research has shown that what consumers report does not match objective comprehension measures.

The Need To Build Additional Knowledge

Meeting participants recommended that baseline and ongoing data be collected to monitor and better understand several topics related to consumer choice and the operation of health insurance exchanges. They spoke about both information that is needed and methods to obtain information. Several noted that it would be helpful to know more about what people care about – the basis for their choices. For example, what features do they consider first? Which quality measures are most important to them? Researchers think that analytical work is needed now to develop plan performance measures that can drive decisions that states and consumers make.

Participants suggested that it would also be helpful to have information on enrollment dynamics in order to answer questions such as: Who is making voluntary choices? How long do people stay in plans? Why do they leave? How quickly do they switch plans when premiums increase or decrease? The topic of risk is one that needs more study as well, according to meeting participants. The issue of how to help consumers, yet avoid risk selection was raised. Researchers are also interested in knowing how much various populations understand about risk.

Research about literacy on several topics - insurance, risk, or health – was also suggested. One person noted that with current low levels of literacy about basic payment issues, there may be more difficulty later as concepts such "bundled payment" and "reference pricing" are introduced. Thus, the development of a scale or assessment tool about health insurance literacy was proposed.

Researchers at the meeting indicated they look to Exchanges as an important potential source of information about market factors, consumer choices, and enrollment dynamics over time. They suggested that states consider data collection and use as they design Exchanges and commented that it is important not to lose the opportunity to provide standard information across Exchanges. One speaker suggested that it is important to think about how to capture descriptive information about state Exchanges in a way that is not burdensome but allows comparisons across states. The question of whether managed care plans as well as states should be units of analysis in some cases was raised.

The desirability of broadly disseminating state-sponsored research was also discussed. Some suggested that there may be a federal role for publicizing best practices and others noted that HHS has a team that can help states get tapped into what other states are doing.

Organizations that work with states may also put case studies on their websites.

Discussants described several methods related to obtaining feedback about consumers. An annual survey of Exchange users was mentioned. The ACA requires development of plan rating systems, and Exchanges are required to provide enrollee satisfaction information about all plans on the Exchange website. Ongoing consumer testing as Exchanges operate was recommended, with the thought that cognitive interviewing will be extremely valuable. Several people mentioned the importance of having systems in place to obtain feedback from navigators and others familiar with the Exchanges. Conducting ongoing focus groups of consumers and other stakeholders was also mentioned.

Conclusion

Health insurance exchanges will play a vital role in a reformed health system as businesses and consumers are faced with opportunities to obtain health insurance coverage and the necessity of choosing among health insurance products. Past research and experience can help inform the choices states make now about how to design and operate Exchanges. People who are expected to use the Exchanges differ from those who have purchased insurance in the past, however, and they will face a changed health insurance market. Exchanges will likely evolve as people become more aware of the choices they have in a reformed system and more familiar with choosing and using health insurance.

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