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CONSUMER HEALTH CARE INFORMATION

Many Quality
Commission
Disclosure
Recommendations Are
Not Current Practice



**Health, Education, and
Human Services Division**

B-279867

April 30, 1998

The Honorable Larry E. Craig
United States Senate

The Honorable Paul D. Coverdell
United States Senate

The Honorable William V. Roth, Jr.
Chairman
Committee on Finance
United States Senate

The rapid changes in the health insurance industry have increased calls for greater information dissemination to enable consumers to make more informed choices. Purchasers of health care, such as large employers and agencies responsible for government employee health plans, have become more active in the information movement as they have adopted “value-based” purchasing strategies. For both purchasers and their employees—who are the ultimate consumers of care—information is considered critical in choosing the highest quality health plan for the dollar and in promoting efficiency and responsiveness in the provision of health care services.

Growing public concern about health care quality has elevated the discussion of health plan information to the national level. As a result, on September 5, 1996, the President created the Advisory Commission on Consumer Protection and Quality in the Health Care Industry and charged it with recommending measures to promote and ensure health care quality and to protect consumers and workers in the health care system. The Commission released its initial recommendations—The Consumer Bill of Rights and Responsibilities—in November 1997.¹ Since then, some Members of the Congress have called for the Consumer Bill of Rights to be adopted into federal law. Others argue that such an increase in regulation would result in higher insurance premiums and increase the number of people unable to afford health insurance. With these issues in mind, you asked us to

¹Advisory Commission on Consumer Protection and Quality in the Health Care Industry, *Consumer Bill of Rights and Responsibilities*, Report to the President of the United States (Washington, D.C.: Nov. 1997). The Consumer Bill of Rights and Responsibilities is also referred to as the Consumer Bill of Rights and the Patient Bill of Rights.

- review the Commission’s recommendations regarding information to be provided to consumers and compare them with the information currently provided to employees of large public and private health care purchasers,
- review the available evidence from purchasers and researchers concerning the extent to which consumers are able to make use of this information, and
- discuss the potential cost of bridging any existing information disclosure gap between the Commission’s recommendations and existing purchaser practices.

To respond to your request, we reviewed the information disclosure chapter of the Consumer Bill of Rights and Responsibilities and transcripts of Commission meetings where this issue was discussed. To compare Commission recommendations with current large purchaser practices, we drew from an extensive body of our work over the last few years focusing on managed care in general, as well as on large purchaser management strategies and quality initiatives. In addition, we contacted officials at, or reviewed health benefits material from, a group of nine large public and private health care purchasers, a purchasing coalition, and a business group. The purchasing coalition and the business group together represent approximately 190 large employers. (For a list of these purchasers and groups, see app. I.)

In making the comparison, we assumed that if a purchaser provided information that only partially fulfilled a recommendation, it did not meet the recommendation. For example, many health plans distribute provider directories during plan selection periods, but few of the directories we reviewed included all of the data the Commission recommended be included, such as whether the providers were accepting new patients, what languages the providers spoke, or whether interpreter services were available. On the other hand, in cases in which the Commission did not elaborate on the level of detail that should be disclosed, we assumed that any information provided regarding a specific data element was equivalent to the Commission’s recommendation. For example, the Commission recommended that health plans provide “information about circumstances under which primary care referral is required to access specialty care.” We assumed that health plan information was consistent with this recommendation if it simply stated that a referral from the primary care physician was required for specialty care.

To address health care consumers’ ability to make use of information, we discussed the issue with health benefits managers and reviewed recent

studies on health plan information and consumer choice. Our review of the potential cost of meeting the Commission's information disclosure recommendations was based on an analysis by The Lewin Group, Inc.² We also discussed the cost implications of the Consumer Bill of Rights with large purchasers' benefits managers.

The firms we included in our review were large—having more than 10,000 employees—and offered a choice of health plans to their employees. We selected these purchasers in part on the basis of our previous work and in part because of their reputations as innovators in the health care purchasing arena. Given that a large percentage of employer-sponsored health care coverage is offered by small- and medium-sized firms, commonly with a single health plan option, the information available to employees of purchasers in our group should not be considered representative of that provided to all insured consumers. Rather, the information disclosure practices discussed in this report represent the leading edge in information collection and dissemination in the nation.

We conducted our review between January and April 1998 in accordance with generally accepted government auditing standards.

Results in Brief

The Quality Commission's Consumer Bill of Rights and Responsibilities recommends that consumers have access to a broad range of information regarding the policies, characteristics, and performance of health plans, professionals, and facilities. Under the Consumer Bill of Rights, each of these components of the health care system would have responsibility for routinely providing a set of specific information to consumers, either directly or through plan sponsors, and making other information available on request. Taken together, the large purchasers in our review, and their associated health plans, currently provide about half of the data elements the Commission recommended be routinely provided to consumers. The information covering conventional health insurance issues, such as covered benefits and cost-sharing, is typically provided by health plans. In addition, performance measures reflecting plans' clinical quality and enrollee satisfaction are generally collected and disseminated by large purchasers. On the other hand, information that the Commission recommended be provided about the business relationships and financial arrangements among health professionals, health care facilities, and health

²In 1997, the Quality Commission contracted with The Lewin Group, Inc., to analyze the benefits and costs of the information disclosure and external appeals provisions of the Consumer Bill of Rights.

plans, as well as measures of service performance, are among the items not routinely reported to consumers.

To be responsive to consumers' information needs, large purchasers disseminate information through a variety of media. Written materials, generally used during open season to assist consumers in their health plan selection, are highly accessible but can become quickly outdated. Electronic dissemination via the Internet overcomes the timeliness problem by rapidly reflecting changes in health plan information, but not all consumers have access to the Internet. Regardless of the format used, however, both the purchasers we interviewed and consumer surveys indicate that many enrollees do not use the health care information made available to them because it is difficult to understand.

According to an analysis performed for the Commission, meeting the Consumer Bill of Rights information disclosure recommendations would add \$0.59 to \$2.17 per enrollee per month to current information-related expenses, depending on the level of detail provided and the time allowed for implementation. The cost increases would initially be borne by physicians, hospitals, health plans, and dissemination sources and could ultimately be passed on to purchasers and consumers. Despite the potential increase in cost associated with providing more and better information, large purchasers indicated that they intend to continue expanding their information development and disclosure efforts because of the value gained through informed choice.

Background

Information disclosure has attracted increased attention because of the desire to protect consumers and the important role information plays in helping consumers make informed choices. Current information disclosure practices have been shaped largely by employers, private accrediting agencies, and governments.

In response to the double-digit increases in the cost of health insurance in the late 1980s, many large purchasers opted for an approach to buying health care that demands more analysis on the part of the purchaser to secure the greatest value for its health care dollar. Using the leverage conferred by their size, many large purchasers pushed health plans to improve their data collection and reporting capabilities, so the purchasers could perform the necessary analysis. For example, together with health plans, large purchasers developed the Health Plan Employer Data and Information Set (HEDIS)—a standardized set of performance measures—as

a tool with which purchasers could compare health plans.³ In some cases, purchasers passed this information and analysis on to their employees to assist them in deciding among competing health care options.

In addition, accreditation agencies such as the National Committee for Quality Assurance (NCQA) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) evaluate health care organizations' clinical and administrative systems and make the results of these evaluations available to employers and the general public.⁴ There is some commonality between the standards for accreditation and the Consumer Bill of Rights information disclosure recommendations. For example, both JCAHO and the Consumer Bill of Rights require the dissemination of information on the scope of covered benefits. But in many other cases, the Consumer Bill of Rights' recommendations are more extensive than accreditation standards. For instance, JCAHO does not require disclosure of state licensure status, federal certification, and private accreditation status, as called for in the Consumer Bill of Rights.

The Congress, in addition to the executive branch, has been active in encouraging greater disclosure of health plan information to consumers. The Balanced Budget Act of 1997 (P.L. 105-33) contains a list of information disclosure requirements for Medicare+Choice plans.⁵ These requirements include an explanation of benefits, premiums, plan service area, quality and performance indicators, and supplemental benefits. On February 20, 1998, the President instructed the Departments of Defense, Health and Human Services, Veterans Affairs, and Labor, as well as the Office of Personnel Management, to bring their various plans and programs (which serve over 85 million people) into agreement with the Consumer Bill of Rights.

³The current version of HEDIS measures—HEDIS 3.0/1998—includes 86 reporting and testing measures in eight areas: effectiveness of care, access/availability of care, satisfaction with the experience of care, health plan stability, use of services, cost of care, informed health care choices, and health plan descriptive information. Over 90 percent of health maintenance organizations (HMO) use HEDIS at the request of the Health Care Financing Administration, state governments, and large commercial employers.

⁴NCQA is an independent, nonprofit organization that reviews and accredits managed care organizations. More than half of the HMOs in the nation have been reviewed by NCQA, and they account for approximately 75 percent of all Americans enrolled in HMOs. JCAHO is an independent, nonprofit organization that accredits health care providers and networks (including health plans).

⁵A Medicare+Choice plan can be any of the following types of health insurance plans: a coordinated care plan—such as an HMO, a provider-sponsored organization, or a preferred provider organization; a combination of a medical savings account plan and contributions to an associated medical savings account; or a private fee-for-service plan.

At the state level, the California Managed Health Care Improvement Task Force recently recommended that “health plans be required to make available and accessible to consumers significant additional information including the following: a ‘standard product description’ to facilitate direct comparison of plans by consumers, up-to-date and specific information on provider access, information on referrals to specialty centers, and plan and medical group independent practice associations’ written treatment guidelines or authorization criteria.”⁶ The National Association of Insurance Commissioners (NAIC) has also addressed the issue of health plan information disclosure in a series of model laws that are being incorporated, to varying degrees, by states as they pass comprehensive consumer protection legislation.⁷

Commission Information Disclosure Recommendations Go Beyond Current Health Plan and Purchaser Practices

In the Consumer Bill of Rights and Responsibilities, the Commission has recommended that consumers receive a broad array of information about health plans, professionals, and facilities.⁸ The rationale given by the Commission is that “active and informed decision making by consumers will improve the performance of the health care system, as providers seek to enhance their quality and reduce their costs in order to be more attractive to value-seeking consumers.” Under the Consumer Bill of Rights, health plans, professionals, and facilities would have responsibility for routinely providing a set of specific information to consumers and making other information available on request. The information routinely provided to employees of the large purchasers in our review covered about half of the data elements that the Commission recommended and focused on health plan benefits and network characteristics. The areas of information disclosure on which the purchasers and the Commission were furthest

⁶The California Managed Health Care Improvement Task Force was created in 1996 to inform the state’s leaders about the current health care industry in California, including the impact of managed care on specific segments of the industry and components of special concern to consumers, and to make recommendations regarding the state’s oversight and regulatory role related to managed care. See California Managed Health Care Improvement Task Force, *Executive Summary* (Sacramento, Calif.: California Managed Health Care Improvement Task Force, Jan. 5, 1998).

⁷NAIC first developed a Health Maintenance Organization Model Act in July 1995. Since then, NAIC has developed model laws covering health care quality assessment and improvement, health care professional credentialing verification, managed care plan network adequacy, utilization review, and health carrier grievance procedures.

⁸The Commission used the term “health plan” to refer broadly to indemnity insurers, managed care organizations (including HMOs and preferred provider organizations), self-funded employer-sponsored plans, Taft-Hartley trusts (union-organized health plans), church plans, association plans, state and local government employee programs, and public insurance programs. The term “consumers” refers to the users of health care, including beneficiaries of public programs, government employees, individuals who purchase their own health insurance, and employees who work for firms that sponsor self-funded plans or provide health insurance products.

apart generally pertained to the business relationships and financial arrangements that health professionals and health care facilities have with health plans.

Commission Recommends Extensive Disclosure of Information on Health Plans and Providers

The Commission's recommendations pertaining to information disclosure are divided into three sections: health plans, health professionals, and health care facilities. Among other things, health plans would be required to provide information on specialty referral rules, professionals would be required to provide information on their board certification status, and facilities would be required to provide information on their experience in performing specific procedures and their accreditation status. For each of the three sections, the Commission made the distinction between those data elements that consumers should receive routinely and those that should be available upon request. Following are the Commission's recommendations for specific components of health plan, professional, and facility information.⁹

Routinely Provided Information

Health plan benefits, cost-sharing, and dispute resolution

- general limits on coverage
- preventive services coverage
- drug formulary operations
- how drugs, devices, and procedures are deemed experimental
- enrollee cost-sharing
- dispute resolution procedures

Health plan characteristics and performance

- state licensure status, federal certification, and private accreditation status
- consumer satisfaction measures
- clinical quality performance measures
- service performance measures
- disenrollment rates

Health plan network characteristics

- aggregate information on the numbers, types, board certification status, and distribution of providers

⁹The elements included in this list would not necessarily apply to all types of health plans; for example, the recommendation for disclosure rules regarding out-of-network services would not apply to a standard fee-for-service indemnity plan.

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- each primary care provider's board certification status, location, availability, languages spoken, and accessibility
 - provider compensation methods
 - rules regarding out-of-network coverage
 - circumstances under which primary care referral is required to access specialty care
 - options for 24-hour coverage and access to urgent care centers

Health professional information

- ownership or affiliation arrangements with a provider group or institution that would make referral to a particular specialist or facility more likely
- how the provider is compensated

Health care facility information

- corporate form of the facility
- accreditation status
- specialty programs' compliance with established guidelines
- volume of certain procedures performed
- consumer satisfaction measures
- clinical quality measures
- service performance measures
- complaint process
- availability of translation or interpretation services
- number and credentials of providers of direct patient care
- affiliation that would make it more likely that referrals would be made within a provider network
- whether facility has been excluded from any federal health program

Information to Be Made
Available on Request

Health plan characteristics and performance

- number of years in existence
- corporate form of the plan
- whether the plan meets federal and state requirements for fiscal solvency
- whether the plan meets federal, state, and private accreditation standards that ensure confidentiality of medical records and orderly transfer of caregivers

Health plan network characteristics

- detailed list of names, board certification status, and geographic location of all contracting specialists and specialty care centers; whether they are accepting new patients; language(s) spoken and availability of interpreter services; and whether facilities are accessible to people with disabilities
- detailed list of names; accreditation status; and geographic location of hospitals, home health agencies, and rehabilitation and long-term care facilities; whether they are accepting new patients; language(s) spoken and availability of interpreter services; and whether they are accessible to people with disabilities

Health plan care management

- preauthorization and utilization review procedures followed
- whether the plan has special disease management programs or programs for people with disabilities
- qualifications of reviewers at the primary appeals level
- use of clinical protocols, practice guidelines, and utilization review standards pertinent to a patient's clinical circumstances
- whether a specific prescription drug is included in a formulary and procedures for considering requests for patient-specific waivers

Health professional information

- education, board certification, and recertification status
- years of practice as a physician and as a specialist if so identified
- consumer satisfaction measures
- service performance measures
- corporate form of practice
- names of hospitals where physicians have admitting privileges
- experience with performing certain medical or surgical procedures, adjusted for case-mix severity
- clinical quality performance measures
- accreditation status (if applicable)
- availability of translation or interpretation services for non-English-speakers and people with communication disabilities
- any cancellation, suspension, or exclusion from participation in a federal program or sanction from a federal agency; any suspension or revocation of medical licensure, federal controlled substance license, or hospital privileges

Consumers Receive Information on Health Plans, but Less on Providers

Employees have access to a considerable amount of information on health plans, but to more limited information on health professionals and facilities. The information is made available by a variety of sources, including health plans, purchasers (including purchasing coalitions), state agencies, accreditation agencies, and the media. Much of the information is required to be disclosed by state insurance laws and regulations.

The health plan data routinely provided to the large purchasers in our review included information on covered benefits and enrollee cost-sharing. Health plan brochures explain general limits on coverage, deductibles (if applicable), and copayments for office visits, and outpatient and inpatient care. Although managed care plans frequently provided lists of their network participants, in some cases this information simply indicated the names and addresses of associated providers; in other cases, it included additional details, such as the physician's training, language(s) spoken, and ability to accept new patients. Information on certain health plan procedures, such as how consumers obtain referrals to specialists, how consumers access after-hours care, how products are included in drug formularies, and the grievance process, was also generally available. However, only 2 of the 10 purchasers we reviewed indicated that their plans provided a detailed explanation of how they deemed drugs, devices, or procedures as experimental (and, therefore, not covered). None explicitly indicated their federal certification and state licensure status, although they did provide information on their private accreditation status.

To augment the information provided by individual plans, large purchasers have compiled and reported to their employees comparative information on plan characteristics and performance. Specifically, these purchasers have informed consumers about consumer satisfaction measures, plan performance on selected clinical quality indicators, and rates of disenrollment from each plan. Generally absent from these comparisons were service performance measures (such as waiting times to obtain an appointment).

Enrollee satisfaction is the most common type of performance information provided by purchasers in our group. Purchasers' satisfaction surveys ranged from a single aggregate measure to a five-part survey, with each part containing at least four measures. For example, the Federal Employees Health Benefits Program (FEHBP) reported satisfaction for each plan as a whole by showing the percentage of federal enrollees who were

extremely satisfied, very satisfied, and somewhat satisfied.¹⁰ For HMOS, FEHBP also reported on satisfaction in several specific areas, including plan coverage, amount of time to get an appointment when sick, seeing the same doctor on most visits, quality of care, thoroughness and competency of the provider, and explanations and results of care.

The most widely used comparative indicator of plan clinical quality is preventive care measures. Some of the purchasers in our review collect HEDIS data from their health plans and issue report cards to their employees on a subset of measures. For example, purchasers reported on the rates of immunizations, cholesterol screening, cervical cancer screening, caesarean sections, and retinal exams for people with diabetes for each available health plan.

The Pacific Business Group on Health (PBGH) also makes report cards on providers available.¹¹ For example, the coalition uses a series of patient surveys to measure satisfaction with medical groups' service and quality of care. It reports data on overall patient satisfaction with particular physician groups, satisfaction with specific preventive care services, and satisfaction ratings for patients with high blood pressure or high cholesterol. PBGH has also developed hospital report cards showing success rates for and overall volume of certain complex procedures, such as organ transplants, as well as utilization rates for more common procedures, such as caesarean sections.

The areas of greatest difference between the Commission recommendations for information to be routinely provided and that which is currently available to consumers involved characteristics of health professionals and health care facilities. Explanations of physician compensation arrangements—including financial incentives for physicians to be conservative in providing services—were not included in any of the information provided to consumers that we reviewed. Information on ownership interests that a provider could have with a hospital or medical group that would make it more likely that a patient would be referred to a particular physician or facility was also unavailable to consumers. Other facility-specific information recommended by the Commission but not routinely disseminated by our large purchasers included data on service performance, complaint filing and resolution procedures, availability of translation or interpretation services, number and credentials of providers

¹⁰FEHBP is the largest employer-sponsored health benefit program in the United States, including 350 carriers and covering 9 million individuals.

¹¹PBGH is a coalition of 33 member firms, covering approximately 2.5 million people.

of direct patient care, and whether a facility has been excluded from any federal health program. Table 1 summarizes the information that is routinely provided by most large purchasers in our review or is publicly available in some regions.

Table 1: Comparison of Information the Commission Recommends Be Routinely Provided With Information Commonly Provided by Large Purchasers

	Commonly provided information
Commission-recommended information	
Health plan benefits, cost-sharing, and dispute resolution	
General limits on coverage	X
Preventive services coverage	X
Drug formulary operations	X
How drugs, devices, and procedures are deemed experimental	
Enrollee cost-sharing	X
Dispute resolution procedures	X
Health plan characteristics and performance	
State licensure status, federal certification, and private accreditation status	
Consumer satisfaction measures	X
Clinical quality performance measures	X
Service performance measures	
Disenrollment rates	X
Health plan network characteristics	
Aggregate information on the numbers, types, board certification status, and distribution of providers	X
Each primary care provider's board certification status, location, availability, languages spoken, and accessibility	
Provider compensation methods	
Rules regarding out-of-network coverage	X
Circumstances under which primary care referral is required to access specialty care	X
Options for 24-hour coverage and access to urgent care centers	X
Health professional information	
Ownership or affiliation arrangements with a provider group or institution that would make referral to a particular specialist or facility more likely	
How the provider is compensated	
Health care facility information	
Corporate form of the facility	
Accreditation status	X
Specialty programs compliance with established guidelines	
Volume of certain procedures performed	X
Consumer satisfaction measures	
Clinical quality measures	X
Service performance measures	
Complaint process	
Availability of translation or interpretation services	
Number and credentials of providers of direct patient care	

(continued)

Commonly provided information

Commission-recommended information

Affiliation that would make it more likely that referrals would be made within a provider network

Whether the facility has been excluded from any federal health program

Large purchasers were not in agreement about the feasibility—at least in the near term—of providing all the information recommended in the Consumer Bill of Rights. Some benefits managers we interviewed expressed concerns about the amount and quality of information to be made public. A public purchaser told us that it does not currently provide plan-level clinical quality data to consumers because the data it receives from health plans are not consistent. A private firm’s manager said that provider-level quality indicators do not exist and, while she believes they would be valuable, she thinks such information is still 5 to 7 years away. A PBGH member firm told us that its health plans were currently providing all the data they were capable of providing. Another reason given for not providing certain information was the difficulty plans have explaining technical or medical concepts. For example, descriptions of compensation arrangements for individual providers can be very difficult to understand because they involve complex concepts, such as percentage of charges, risk-adjusted capitation, risk pools and withholds, bonuses, case rates, and fee schedules. Similarly, a description of how plans determine whether a drug, device, or procedure is deemed experimental can involve complex technical and medical concepts. One benefits manager told us she had never seen an explanation of this process that could be easily understood.

Other purchasers were more positive. One human resources executive said that the Commission’s recommendations “reflect a realistic set of consumer healthcare standards.” Moreover, this firm publicly announced that it was committed to implementing the recommendations. Similarly, an FEHBP official recently testified that the program substantially complies with the broad principles of the Consumer Bill of Rights and that all participating carriers are expected to fully comply by 2000. (See app. II for a comparison of the Commission’s information disclosure recommendations and the information currently provided by FEHBP.)

Consumer Information May Be Difficult to Obtain and Interpret

The Commission recognized that for consumers to benefit from information disclosure, health care information must be accurate, easy to understand, and available when needed. It also acknowledged that consumers’ capacity to understand health care information may be taxed by the volume disclosed—that too much information becomes

overwhelming. Furthermore, the Commission stated that some consumers require assistance in making informed decisions and should be supported by plan sponsors. Some of the purchasers in our review found that consumers often have difficulty interpreting much of the information provided, a view that appears to be supported by research on this issue. Believing that their employees may lack the time or knowledge to make sense of the information, some of the purchasers in our review are taking steps to reduce the amount and level of detail in the data they disseminate.

Purchasers Provide Information in a Variety of Formats

Most purchasers that offer a choice of health plans use a variety of means to help individual consumers make better decisions about which health plan and providers to select. Health care information is commonly disseminated in written materials distributed once each year during health benefits open season. The purchasers in our review provided documents comparing consumers' options in a report card format, and the associated health plans provided standard information about benefits, costs, and provider networks.

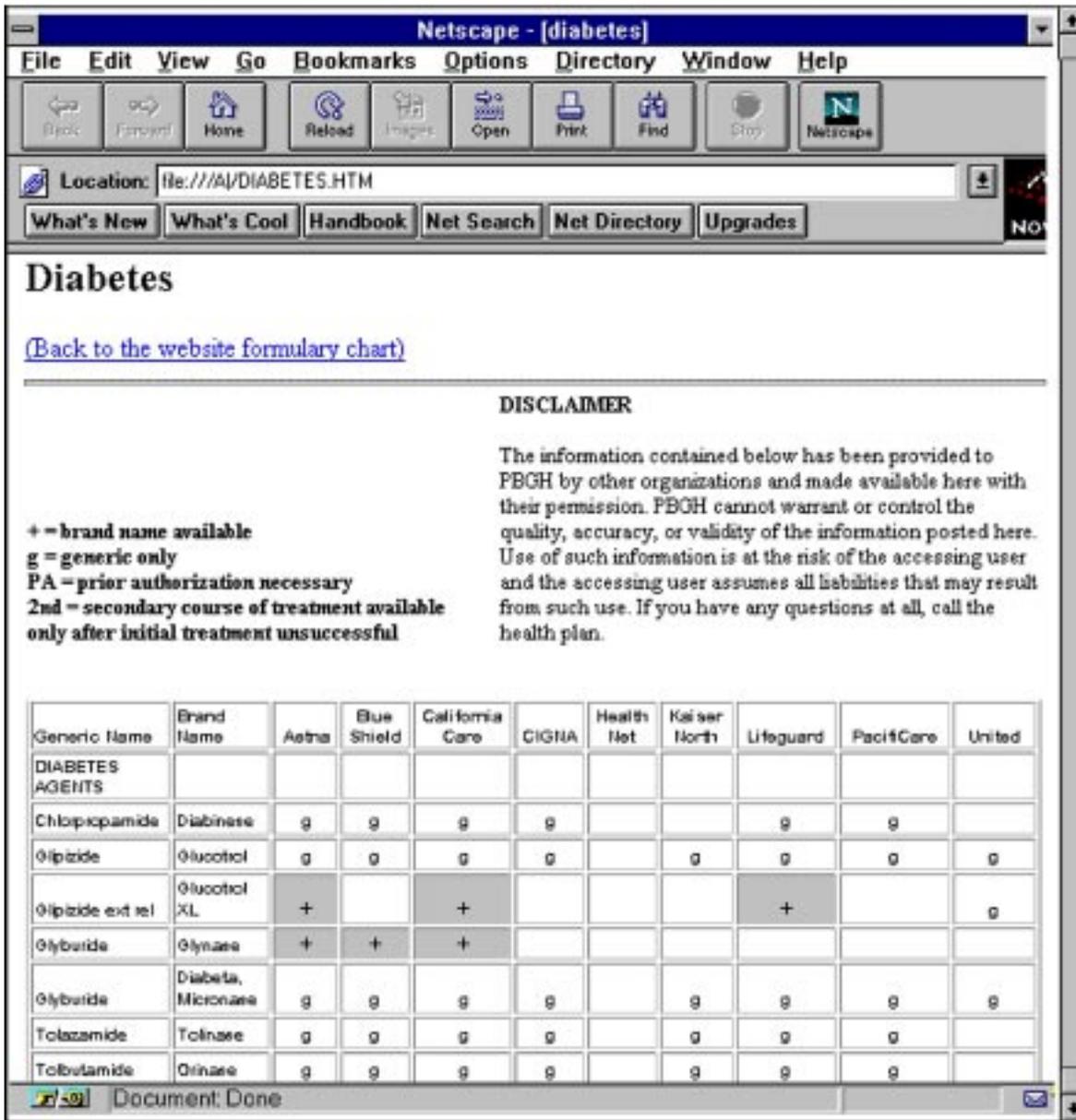
Because written materials do not remain up-to-date, however, some purchasers have expanded their information dissemination efforts to include additional formats, such as the Internet. There are times—other than during annual enrollment periods—when enrollees may need specific health plan information. For example, consumers may want to change primary care physicians or require a specialist and need current information on which physicians participate in the plan's network and who is accepting new patients. At this point, the provider directory that consumers received at open season may already be out-of-date. To keep consumers current about changes in the network and other newly available information, some purchasers are taking advantage of the flexibility inherent in electronic formats, such as company intranets and the Internet. One purchaser links The Health Pages—an Internet site specializing in local provider and health plan information—to the company intranet, so its employees can access information when needed about particular physicians affiliated with their health plan. But these formats also have their drawbacks; for example, not all consumers have access to the Internet or the skills necessary to use it.

PBGH puts its health plan, physician group, and hospital report cards as well as satisfaction survey results on a web site.¹² Figure 1 shows a “page” from the PBGH Internet site containing information about the availability of

¹²PBGH produced this web site with the support of the Henry J. Kaiser Family Foundation.

prescription drugs for consumers with diabetes across various health plans. Recognizing that not all consumers have access to the Internet, PBGH also makes an abbreviated printed version of its comparative characteristics and performance information available upon request.

Figure 1: Sample Health Plan Drug Information Provided by PBGH on the Internet



Source: PBGH Internet site.

Information Is Not Always Translated Into a Form Useful to Consumers

Providing consumers with information to compare health plans and providers presupposes that individuals have the resources to make sense of it.¹³ Some information is not easy to translate from technical or legal terminology to consumer-friendly language. To help consumers interpret the information disclosed, some purchasers try to educate consumers about health care in general and managed care in particular. For example, one purchaser's open enrollment brochure included an explanation of the role of a primary care physician in a point-of-service plan or HMO. Another purchaser explained the different levels of NCQA accreditation and the HEDIS quality measures included for comparison.

Consumers appear to be interested in comparative health plan information, but purchasers need to learn more about how to adjust the information to meet consumers' needs.¹⁴ One PBGH member told us that the coalition is considering streamlining the information provided on its Internet site because there may be too many layers. One large public purchaser has revised its health plan report card format three times in the last 3 years in an attempt to make it easier to use. After watching employees "struggle" with the information they receive, a private benefits manager told us her firm has adopted a strategy of concentrating on employee education and incremental increases in the amount of information provided, to allow employees to become more comfortable with making decisions on the basis of comparative data.

A review of recent literature on quality information supports much of what officials from the purchasers in our group told us. In choosing a health plan, consumers say that quality of care is their greatest concern, but they ultimately make their decisions on the basis of personal recommendations rather than quality data.¹⁵ When screening health plans for participation in their programs, the purchasers frequently consider comparative performance measures like HEDIS, but consumers do not appear to find these same measures particularly useful.¹⁶ One study found that more than three-quarters of its respondents would choose to see a surgeon they knew

¹³Marc A. Rodwin, "Managed Care and Consumer Protection: What are the Issues?" Seton Hall Law Review, Vol. 26:1007 (1996), p. 1033.

¹⁴Jack Meyer, Elliot Wicks, Lise Rybowski, and others, Report on Report Cards: Initiatives of Health Coalitions and State Government Employers to Report on Health Plan Performance and Use Financial Incentives (Washington, D.C.: Economic and Social Research Institute, Mar. 1998).

¹⁵Henry J. Kaiser Family Foundation, "New National Survey: Are Patients Ready to Be Health Care Consumers?" Press Release (Menlo Park, Calif.: Kaiser Family Foundation, Oct. 28, 1996).

¹⁶Anne Tumlinson, Hannah Bottigheimer, Peter Mahoney, and others, "Choosing a Health Plan: What Information Will Consumers Use?" Health Affairs, Vol. 16, No. 3 (1997), pp. 236-37.

instead of one they didn't know but who had much higher ratings.¹⁷ One explanation for the apparent contradiction between the information consumers say they want and what they actually use is that information on quality may not be clearly presented.¹⁸ Moreover, consumers lack a fundamental understanding of how managed care works.¹⁹ Among the information that purchasers provide, consumers find details on cost, benefits, and the availability of providers most useful; performance measures are more difficult to understand and, as a result, may be used less often.²⁰

Purchasers Continue to Expand Information Disclosure Efforts Despite Potential Costs

An analysis done for the Commission concluded that developing and disseminating the recommended information would increase premiums by a relatively small amount. While none of the purchasers in our group met all the Commission's recommendations for information disclosure, they reported that the cost of complying did not appear to be a major obstacle. Moreover, some purchasers told us that they see pursuit of health care information as a process requiring continuous improvement and that they plan to continue with their efforts.

Information Disclosure Costs Estimated to Add About 1 Percent to Premiums

The Lewin Group has estimated that the additional cost of developing and disseminating information needed to fully implement the Commission's recommendations would range from \$0.59 to \$2.17 per enrollee per month, or about 1 percent of premiums.²¹ While we did not perform an independent cost assessment, some important aspects of this analysis were consistent with the information we obtained from the purchasers in our review. For example, the Lewin analysis explains that the most expensive component of information disclosure is the cost of obtaining quality and satisfaction information regarding individual physicians, largely because of the sheer number of physicians and the labor intensity

¹⁷"New National Survey: Are Patients Ready to Be Health Care Consumers?" Kaiser Family Foundation.

¹⁸Anne Tumlinson and others, "Choosing a Health Plan: What Information Will Consumers Use?" p. 237.

¹⁹Judith H. Hibbard and Jacquelyn Jewett, "Will Quality Report Cards Help Consumers?" *Health Affairs*, Vol. 16, No. 3 (1997), p. 226.

²⁰Judith H. Hibbard and Jacquelyn Jewett, "Will Quality Report Cards Help Consumers?" p. 226.

²¹Allen Dobson, Caroline Steinberg, Ray Baxter, and others, *Consumer Bill of Rights and Responsibilities Costs and Benefits: Information Disclosure and External Appeals* (Fairfax, Va.: The Lewin Group, Inc., Nov. 18, 1997). We calculated the incremental cost as a share of health insurance premiums assuming purchasers' cost of \$160 per member per month. Cost estimates associated with federal legislative proposals addressing some of the Commission's recommendations are currently being developed by the Congressional Budget Office.

of collecting the information. Some of the purchasers in our group said that individual provider-level data have been and will continue to be among the most difficult to obtain.

In developing its estimates, The Lewin Group made various assumptions regarding the level of detail in the information to be provided. For example, the Commission recommends that health plans and providers report service performance measures, but it does not specify how detailed these measures should be. A long, complicated survey, possibly involving several areas of health plan operations, would be expected to be more expensive than a single-indicator survey. To account for such variation, Lewin offered three estimates of cost: low, mid-point, and high. Lewin also assumed that costs would be lower if health plans were allowed to meet the recommendations over a longer period of time. Table 2 summarizes the Lewin cost estimates.

Table 2: Information Disclosure Cost Estimates for Two Implementation Periods, per Insured Person per Month

	Implementation time frame	
	1 year	3- to 5-year phase-in
Low estimate	\$0.80	\$0.59
Mid-point estimate	1.49	0.84
High estimate	2.17	1.10

Source: The Lewin Group, Inc.

Although the burden of providing the recommended information would initially fall on health plans and providers, how these costs would ultimately be financed is uncertain. Plans, for example, could pass costs on to purchasers through premium increases. Alternatively, plans could absorb the increased costs or recoup the additional costs by lowering reimbursements to providers. While acknowledging that pursuing more and better information might lead to an increase in premiums, some of the purchasers we interviewed said they would continue their efforts.

Purchasers Continue to Seek Improvements in Health Care Information

In making its recommendations, the Commission has recognized the importance of continuous improvement in health care information quality and disclosure. According to the Commission, there is a need for greater standardization in definitions as well as in clinical quality, service performance, and customer satisfaction measures. Several of our

purchasers identified improvement in the standardization and quality of data as critical to improving value-based purchasing.

Current initiatives designed to address the issue of consistency in data collection and dissemination include an Employers' Managed Health Care Association²² project to encourage large purchasers to eliminate unique elements within their requests for health plan proposals at contracting time. The health plans and large purchasers in this project agree that the health care system would benefit from more consistent data requests from purchasers. At the same time, large purchasers are striving to improve the quality and reliability of data reported by health plans. For example, PBGH uses independently verified HEDIS data in its quality reports, and NCQA plans to incorporate selected HEDIS measures in its accreditation process in the summer of 1999. As a result, purchasers who require private accreditation in order to participate in their health care programs will have a consistently reported and collected data set at their disposal.

Also with consistency in mind, the Department of Health and Human Services' (HHS) Agency for Health Care Policy and Research developed and released a new customer survey instrument—the Consumer Assessments of Health Plans Study (CAHPS)—in March 1998.²³ The survey covers specific plan features, such as access to specialists and quality of patient-physician interaction, and includes questions geared to consumers with special characteristics, such as those with chronic conditions, children, Medicaid recipients, and Medicare beneficiaries. The Agency for Health Care Policy and Research is working with NCQA to merge CAHPS and the HEDIS 3.0 Member Satisfaction Survey, currently used by many health plans, to arrive at a single, standard set of survey instruments for national use in making health plan comparisons. HHS and the Agency for Health Care Policy and Research have begun using CAHPS with beneficiaries in Medicare managed care plans, and the Office of Personnel Management has adopted it for use with FEHBP enrollees in 1999.

Conclusion

The calls for health care information disclosure are not new. The movement among large employers and health plans has already produced standardized data on a number of measures important to purchasers. The

²²The Employers' Managed Health Care Association is an organization of more than 100 large employers.

²³The new Agency for Health Care Policy and Research-sponsored instrument was developed by a consortium of Harvard Medical School, RAND, and Research Triangle Institute researchers and involved the participation of health plans, purchasers, and accreditation agencies.

Consumer Bill of Rights and Responsibilities would extend these efforts by adding information that is not typically provided, even by large purchasers. The ability of consumers to use the information already being provided, as well as any additional data, will continue to require attention.

Comments and Our Evaluation

We provided copies of a draft of this report to officials of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry as well as to officials of the Office of Personnel Management for review. These officials generally agreed that the report was accurate and suggested a few technical revisions, which we incorporated where appropriate.

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies to interested parties and make copies available to others on request. Please call me on (202) 512-7119 if you or your staff have any questions. Staff who contributed to this report include Rosamond Katz and Mark Ulanowicz.



Bernice Steinhardt
Director, Health Services Quality
and Public Health Issues

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Abbreviations

CAHPS	Consumer Assessments of Health Plans Study
FEHBP	Federal Employees Health Benefits Program
HEDIS	Health Plan Employer Data and Information Set
HHS	Department of Health and Human Services
HMO	health maintenance organization
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
NAIC	National Association of Insurance Commissioners
NCQA	National Committee for Quality Assurance
PBGH	Pacific Business Group on Health

Large Health Care Purchasers Included in This Review

In conducting our review, we examined samples of employee health benefits materials or contacted health benefits officials at the following organizations.²⁴

PRIVATE FIRMS

Chevron

General Motors

IBM

PepsiCo

Southern California Edison

Xerox

PRIVATE PURCHASING COALITION

Pacific Business Group on Health

PUBLIC HEALTH BENEFITS ADMINISTRATORS

Federal Employees Health Benefits Program

Minnesota Department of Employee Relations

²⁴We also consulted with the Washington Business Group on Health, an organization that includes large public and private employers. In addition, the purchasers in our review included a private firm that asked that we not use its name.

Information Disclosure Under the Federal Employees Health Benefits Program

The Federal Employees Health Benefits Program (FEHBP) is the largest employer-sponsored health benefits program in the United States. The program covers approximately 9 million enrollees and includes 350 health insurance carriers. Through FEHBP, federal employees have a choice of fee-for-service plans, preferred provider organizations, point-of-service plans, and health maintenance organizations. FEHBP currently provides information consistent with several components of the Commission's recommendations for routine disclosure, particularly those pertaining to health plan benefits, characteristics, and performance. However, neither FEHBP nor its associated health plans provided detailed information on specific health professionals or facilities, such as disclosure of financial incentives. Table II.1 indicates which of the Commission's information disclosure recommendations we found to be routinely provided by FEHBP or its participating health plans in 1997.

**Appendix II
Information Disclosure Under the Federal
Employees Health Benefits Program**

Table II.1: Comparison of Information the Commission Recommends Be Routinely Provided With Information Provided by FEHBP and Plans

Commission-recommended information	Information provided to FEHBP enrollees
Health plan benefits, cost-sharing, and dispute resolution	
General limits on coverage	X
Preventive services coverage	X
Drug formulary operations	X
How drugs, devices, and procedures are deemed experimental	
Enrollee cost-sharing	X
Dispute resolution procedures	X
Health plan characteristics and performance	
State licensure status, federal certification, and private accreditation status	
Consumer satisfaction measures	X
Clinical quality performance measures	
Service performance measures	
Disenrollment rates	
Health plan network characteristics	
Aggregate information on the numbers, types, board certification status, and distribution of providers	
Each primary care provider's board certification status, location, availability, languages spoken, and accessibility	
Provider compensation methods	
Rules regarding out-of-network coverage	X
Circumstances under which primary care referral is required to access specialty care	X
Options for 24-hour coverage and access to urgent care centers	
Health professional information	
Ownership or affiliation arrangements with a provider group or institution that would make referral to a particular specialist or facility more likely	
How the provider is compensated	
Health care facility information	
Corporate form of the facility	
Accreditation status	
Specialty programs' compliance with established guidelines	
Volume of certain procedures performed	
Consumer satisfaction measures	
Clinical quality measures	
Service performance measures	
Complaint process	
Availability of translation or interpretation services	
Number and credentials of providers of direct patient care	

(continued)

**Appendix II
Information Disclosure Under the Federal
Employees Health Benefits Program**

Commission-recommended information

**Information
provided to FEHBP
enrollees**

Affiliation that would make it more likely that referrals would be made within a provider network

Whether the facility has been excluded from any federal health program

Related GAO Products

Health Insurance: Management Strategies Used by Large Employers to Control Costs ([GAO/HEHS-97-71](#), May 6, 1997).

Medicare Managed Care: HCFA Missing Opportunities to Provide Consumer Information ([GAO/T-HEHS-97-109](#), Apr. 10, 1997).

Medicare HMOs: Potential Effects of a Limited Enrollment Period Policy ([GAO/HEHS-97-50](#), Feb. 28, 1997).

Medicare: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance ([GAO/HEHS-97-23](#), Oct. 22, 1996).

Medicaid: States' Efforts to Educate and Enroll Beneficiaries in Managed Care ([GAO/HEHS-96-184](#), Sept. 17, 1996).

Health Care: Employers Urge Hospitals to Battle Costs Using Performance Data Systems ([GAO/HEHS-95-1](#), Oct. 3, 1994).

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