American Heart Association | American Stroke Association

December 21, 2012

The Honorable Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
ATTN: CMS-9962-NC
PO Box 8010
Baltimore, MD 21244-8010

RE: File Code CMS-9962-NC (Request for Information Regarding Health Care Quality for Exchanges)

Dear Administrator Tavenner:

On behalf of the American Heart Association (AHA), including its American Stroke Association (ASA) division, and more than 22 million volunteers and supporters, we appreciate this opportunity to offer our comments on the questions contained in the Request for Information (RFI) regarding Health Care Quality for Exchanges under the Affordable Care Act (ACA).

We were pleased to note that one of the priorities of the National Strategy for Quality improvement in Health Care (National Quality Strategy) includes promoting the most effective prevention and treatment for the leading causes of mortality, starting with cardiovascular disease. AHA/ASA shares this priority and believes promoting effective prevention and treatment is critical to meeting our goal to improve the cardiovascular health of all Americans by 20 percent and to reduce cardiovascular and stroke mortality by 20 percent by 2020. The National Quality Strategy can facilitate improvements in the delivery of health care and sharing of best practices to promote effective quality care and efficient use of health care resources.

In addition, the AHA/ASA has long recognized that it is essential for all Americans to have access to affordable, adequate, quality health insurance coverage in order to meet our goals. Beginning next October, millions of currently uninsured consumers will gain access to affordable health insurance coverage through the new Exchange marketplaces. Many of these consumers have low health insurance literacy, and some may never have had health insurance. During this unprecedented coverage expansion, it is critically important that consumers have access to quality information related to their Qualified Health Plan (QHP) options as they make their initial enrollment decision. We know that once consumers have chosen a health plan, they are likely to remain with that coverage in subsequent years unless compelled to switch plans. Therefore, if we want consumers to enroll in the highest quality health plans – and we certainly do – we need to make at least some quality information available by next October, rather than waiting until 2016 to implement a quality reporting strategy for QHPs. This is particularly important because HHS has adopted

an “any willing health plan” approach to certifying QHPs for the federally facilitated Exchanges and many states are following suit.

We welcome the Department’s questions specifically addressing these topics. To that end, our responses to some of the questions posed in the RFI follow.

Understanding the Current Landscape

2. What challenges exist with quality improvement strategy metrics and tracking quality improvement over time (for example, measure selection criteria, data collection and reporting requirements)?
The key challenge that exists with quality improvement strategy metrics and tracking quality improvement over time is the absence of standard definitions and coding systems across federal and state health programs, private insurers, accreditors and other private entities with quality improvement initiatives, hospitals and other health care settings, and other health care providers. Government and private registries, researchers, claims databases and private sector quality improvement strategies use a variety of definitions and coding methodologies and metrics to track quality improvement over time. The result is duplicate data entry and unique data collection that cannot be merged, linked or aggregated for public policy purposes, plan management, research, or performance metrics across hospitals, providers or guideline programs. A few examples illustrating this challenge follow:

- Hospitals are required to submit data to CMS for Medicare and commercial Medicaid patients that may not be 100 percent aligned with the data elements that the hospital is required to collect for various quality improvement based programs, including the AHA/ASA Get With The Guidelines® program or the AHA/ASA/The Joint Commission (TJC) Primary Stroke Center Certification program. Hospitals utilize these quality improvement programs to focus on specific areas that may not be an emphasis of CMS Core Measures submission requirements. In fact, there are over 2,000 hospitals that utilize the AHA/ASA Get With The Guidelines program and over 6 million patient records entered as of December 2012. These programs have led to more than 200 peer-reviewed manuscripts providing the evidence-based medicine and clinical science that help drive cardiovascular care recommendations.
- Hospitals are currently required to maintain multiple data registries to meet the various requirements and it is difficult to ensure that the data is being collected appropriately for each registry. For example, Get With The Guidelines may not ask the questions the same way as The Joint Commission, and as a result, the various registries do not collect or contain the same information, making it more challenging to improve patient care and outcomes.
- Multiple oversight groups, such as the ACC/AHA Performance Measures Task Force or Clinical Data Standards Task Force, have a mission to help ensure that the right care is being provided to the patient. They utilize clinical expertise and evidence-based research findings to provide the most appropriate recommendations for coding instructions, data definitions, and data measures that will make the most significant impact in cardiovascular quality care.
- Standardized data definitions and instructions would reduce laborious charting that takes time away from patient care. In addition, it can take up to 17 years to move from guideline recommendation to physicians practicing the guideline on a consistent basis. Standardization, again, could help move the use of evidence-based guidelines into practice more quickly.

If these data challenges are not addressed, it will be extremely difficult to meet the aims and priorities of the National Quality Strategy.

What strategies (including those related to health information technology) could mitigate these challenges?
HHS has taken a key step in addressing the challenges involved in quality improvement activities by requiring health plans, hospitals, physicians and other providers along with government programs to convert to the world standard data coding classification system, ICD-10. ICD-10 provides the needed universal infrastructure to more accurately code the delivery of care and track quality improvement initiatives across health care settings, health plans and government programs and research activities. Widespread use of ICD-10 coding will allow health plans and clinicians to share better data for improvement and care coordination activities, thereby facilitating a better understanding of diagnoses and better treatment.

Government programs as well as private organizations like The Joint Commission and the National Quality Forum (NQF) should work collaboratively to use the same standard data coding definitions, data elements and metrics for all data collection and reporting activities, such as registries or guideline monitoring programs. This approach will allow health plans, hospitals and providers to enter data once that can then be accessed for multiple quality improvement initiatives involving government programs, private accreditation organizations, and research studies. Moreover, federal and state quality improvement initiatives and programs should be coordinated and use guidelines such as Get With The Guidelines for stroke, heart failure, heart attack, and resuscitation patients in defining the data elements that are entered into the hospital's quality improvement registries and used to measure performance and outcomes. Finally, CMS and other data registries need to be linked to reduce duplicate data entry and leverage the data for analysis and reporting patient outcomes.

Over time, greater use of health information technology should help facilitate the collection of data and ease the burden of reporting and analysis. However, it is important that e-measures are appropriately tested to ensure that the results are valid when compared to manually abstracted measures.

3. Describe current public reporting or transparency efforts that states and private entities use to display health care quality information?
Public reporting of health care quality information by states and private entities is primarily through federal and state government websites and reports and by private entities such as the National Committee for Quality Assurance (NCQA) and URAC. A number of states, for example Colorado, California, Maryland, and Virginia, have state-sponsored websites that display quality information about health plans, hospitals and in some instances physicians. Medicare also makes quality information available about Medicare Advantage plans, Part D prescription drug plans, and certain types of health care providers. A number of these sites also incorporate health plan accreditation status and performance on clinical quality measures, such as Healthcare Effectiveness Data and Information Set (HEDIS), and patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. HEDIS and CAHPS are national standardized tools used to measure health plan performance on important dimensions of care and service, and assess patients' experiences of care, respectively.

The NQF is the primary endorser of healthcare quality measures based on national standards and developed by consensus of a wide range of health care stakeholders. NQF-endorsed measured are used for a wide variety of purposes, including public reporting, paying for quality, disease surveillance, accreditation, and professional certification or recognition programs. To the maximum extent possible, NQF-endorsed measures should be used in the quality reporting program for QHPs.

The Agency for Healthcare Research and Quality (AHRQ) also produces a web tool, called State Snapshots (http://statesnapshots.ahrq.gov), that provides state-level data on summary quality of care performance measures in areas such as overall health care quality, types of care (preventive, acute, and chronic), settings of care (hospitals, ambulatory care, nursing home, and home health), specific clinical conditions (such as heart disease), and special areas of focus (such as health disparities). This web-based tool may provide some instructive lessons to CMS on the displaying of health care quality information and providing transparency about performance across and within states.

Applicability to the Health Insurance Exchange Marketplace

5. What opportunities exist to further the goals of the National Quality Strategy through quality reporting requirements in the Exchange marketplace?
The general approach and foundation for quality reporting among health plans currently is accreditation and the reporting of performance through HEDIS and CAHPS. This approach can also serve as the basis for a quality reporting strategy for QHPs in the Exchange marketplaces, beginning immediately in 2013.

The accreditation process serves as an important tool for ensuring that health plans are providing high quality care and good customer service and provides a significant opportunity to further the goals of the National Quality Strategy. All accredited plans meet the same standards and performance measures and the results can be used to identify opportunities to drive the national health care strategy as well as identify areas for improvement in a given state. A significant number of issuers have already demonstrated their commitment to quality by voluntarily obtaining private accreditation and publicly reporting enrollee experience and clinical outcomes. Consequently, the data collection and other elements required to provide accurate and comparable information across health plans within a state or nationally are already available year over year to provide longitudinal performance results. Use of validated accreditation measures and leveraging the existing health plan accreditation information to allow consumers to make meaningful, apples-to-apples comparisons of QHPs should continue to be a driving principle in the National Quality Strategy.

Another important opportunity to move the National Quality Strategy forward is expanding the quality reporting requirements for hospitals and providers to promote high quality affordable care using quality outcome measures that link the costs of certain hospitals and providers to quality outcomes. Transparent and comparable outcome information can play a key role in demonstrating value and helping consumers choose high quality providers that provide services at affordable costs. A recent study funded by the Agency for Healthcare Research and Quality (AHRQ) found that consumers equate cost with quality. When asked to choose a health care provider based only on cost information, consumers chose the more expensive option. However, when consumers were shown the right mix of cost and quality information, they were better able to choose health care providers who delivered high-quality care at a lower cost.[1] This study has important implications for the display of cost and quality information to consumers.

[1] *Study Finds Consumers Choose High-Value Health Care Providers When Given Good Cost and Quality Information*. Press Release, March 5, 2012. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/news/press/pr2012/highvaluepr.htm

6. What quality measures or measure sets currently required or recognized by states, accrediting entities, or CMS are most relevant to the Exchange marketplace?
The quality measures that are most relevant to the Exchange marketplace are local health plan performance on clinical quality measures, such as HEDIS, and patient experience ratings on the standardized CAHPS survey. Making information about accreditation status and performance on HEDIS and CAHPS measures publicly available for QHPs can serve as the basis for an effective quality management system, particularly initially.

Requiring accreditors to use a standardized set of quality metrics – with the ability to "drill down" to the specific measures for comparability across QHPs is also relevant to the Exchange marketplace. QHPs, irrespective of product type (e.g. HMO, HMO/POS, PPO), and Medicaid QHPs should be required to report on the same measures in the same way. (We recognize that certain types of plans, such as Medicaid plans, may serve a less healthy population. However, we believe this challenge can be overcome.)

Measures should be based on national standards, the primary sources of which should be measures endorsed by the NQF. When non-NQF measures are used (because NQF measures do not exist), it should be with the understanding that they will be replaced by comparable NQF endorsed measures when available. Where NQF-endorsed measures do not exist, the next level of measures that should be considered, to the extent practical, should be those endorsed by other entities with a consensus process for developing and approving measures, such as national accrediting organizations like NCQA, The Joint Commission or federal agencies.

7. Are there any gaps in current clinical measure sets that may create challenges for capturing experience in the Exchange?
Yes. We recognize that using HEDIS and CAHPS data initially in 2013 means that the data will not reflect the exact exchange population of the QHPs. However, the quality record of an issuer serving existing enrollees is likely to be a good proxy for the kind of coverage and care it will offer in the Exchange. We understand that it will take time to collect quality measures specific to the enrollees in QHPs, but meanwhile, many plans have been collecting and reporting HEDIS and CAHPS data for accreditation purposes for several years. Therefore, requiring this information to be made publicly available at the plan level immediately in 2013 should not be overly burdensome.

In addition, as noted in the answer to question 2, the lack of standard definitions and coding rules creates challenges for capturing experiences across plans within the Exchange. Hospitals and providers involved with clinical measurement sets may be using different definitions and coding rules and instructions. Also, data may be entered in a variety of forms including free text which leads to difficult to interpret data collection. As a result, clinical measures sets or QI initiatives are subject to various interpretations and cannot be compared across different hospitals and providers or aggregated in a meaningful way that can be used for decision making about quality in the Exchange. Additionally, various clinical measure sets have different inclusion and exclusion criteria. This changes the way that the data may be reported and limits the ability to link or merge data in to one database or registry to capture the hospital, health care provider and health plan experiences of consumers in the Exchanges. By helping to provide standardization, we may be able to tell more about the patient populations that are within these databases, and this information can then be used by providers and health plans for targeted quality improvement.

8. What are some issues to consider in establishing requirements for an issuer's quality improvement strategy?
A key issue to consider in establishing requirements for an issuer's quality improvement strategy is the definition of Quality Improvement activities included in the Medical Loss Ratio (MLR) regulation.

Health plans can play a critical role in improving the quality of care – and should be encouraged to do so. HHS requirements for requiring plans to report on their QI activities should follow the carefully defined scope of QI activities in the MLR so that the issuer's activities are valid and clinically appropriate for their enrollees. Examples include benchmarking providers to stimulate improvements, rewarding evidence-based, high quality care, providing data to understand patterns of care and opportunities for improvement, helping patients manage their own conditions, reducing readmissions, reducing health care disparities, and encouraging adoption and use of health IT. HHS should set out clear metrics for the quality improvement strategies outlined in section 1311(g)(1) of the ACA and require use of standard definitions, data elements and collection methodologies to measure and track an issuer's quality improvement strategies and outcomes.

How might an Exchange evaluate the effectiveness of quality improvement strategies across plans and issuers?
In the early years of QHP certification, accreditation is being used as a proxy for evaluating the quality improvement strategies across plans and issuers. We recognize the many demands placed on the Department and on states in getting the Exchanges up and running and acknowledge the complexity of developing effective, standardized quality ratings and quality improvement initiative standards for QHPs. As we've already indicated, however, we believe that accreditation, combined with the reporting of some HEDIS and CAHPS data, could form a reasonable approach to the initial reporting of quality information.

In addition to accreditation, the ACA requires Exchanges and QHPs to meet and report on a number of other quality-related elements, including: 1) quality improvement strategies of QHPs; 2) quality measure data and ratings made available by Exchanges for each QHP as part of consumer assistance tools; and 3) a consumer satisfaction survey. These are all distinct and important types of information for consumers. HHS needs to provide more specific information on its timeframe for issuing guidance and additional information on the process(es) it intends to use to develop, test and administer these elements. When developing the public reporting requirements for a standardized set of quality metrics – which is important to ensure comparability across QHPs –we support the stated intent to align measures with existing programs.

In the future, QHPs should be held accountable for their results – with clear goals and benchmarks – so that consumers and employers will know whether plans are hitting the quality improvement and cost containment targets over time. The Department should clearly distinguish these requirements in future guidance and continue to move forward as swiftly as possible on implementing the range of Exchange quality requirements included in the ACA.

Exchanges should also be required to encourage plans (possibly through bidding or other negotiation processes or through the rating system) to develop and implement effective cost containment, care management, health IT and quality improvement activities. Exchanges should be authorized to develop "reward" systems for plans that effectively use payment reforms and quality improvement tools to deliver better health care to more people at a more affordable price, including making necessary investments to build a strong foundation of comprehensive, well-coordinated primary care. This could be done through the rating system that will be developed for plans, or if the Exchange requires plans to bid to participate, it could be taken into account in the bidding process.

9. What methods should be used to capture and display quality improvement activities?
The methods used to capture and display quality information and quality improvement activities to consumers must be relevant, digestible and actionable for them to make informed purchasing decisions. It would also be helpful if these activities and their results are quantifiable and measurable so that consumers can make apples-to-apples comparisons among health plans.

What publicly and privately funded activities to promote data collection and transparency could be leveraged (for example, Meaningful Use Incentive Program) to inform these methods?
The AHA has invested in and built on scientific knowledge and evidence-based guidelines to develop a suite of quality improvement initiatives that could be leveraged to promote data collection and transparency with respect to the treatment and prevention of cardiovascular disease. AHA's Get With The Guidelines program, with its registry, quality improvement and decision-support functions, has proven to be particularly effective in helping to translate advances made in cardiovascular disease and stroke research into improved patient care at the bedside. As referenced earlier, more than 2,000 hospitals participate in Get With The Guidelines and it now has over 6 million patient records. The AHA/ASA has also partnered with the American Cancer Society and the American Diabetes Association on The Guideline Advantage™. The program utilizes data collected through existing electronic health record or health technology platforms to report on adherence to established guidelines. The Guideline Advantage provides quarterly feedback reports, including both state and national benchmarks, as well as quality improvement resources and formal recognition for active participation in the program. The decade-long success of Get With The Guidelines clearly demonstrates the value of guidelines-based performance assessment and process improvements to consistent improvements in the quality of care.

In addition, we strongly recommend prioritizing measures that are being used concurrently by public and private sector purchasers and payers. Purchasers in the private sector, as well as states serving as purchasers for their public employees and Medicaid enrollees, are using innovative tools to assess the quality and value of health plans when making contracting decisions. We believe that in order to drive the alignment necessary to truly improve quality and reduce costs across the board, these purchasers, along with Exchanges, must "row in the same direction," and use – wherever possible – the same quality measures to hold health plans accountable.

10. What are the priority areas for the quality rating in the Exchange marketplace? (for example, delivery of specific preventive services, health plans performance and customer service)?
The priority areas for the quality ratings in the Exchange are plan accreditation status (including score) and HEDIS and CAHPS scores (where possible using a composite format). Some of these measures that are already being collected and reported and that are of the greatest interest to a wide range of consumers could be selected initially. For example, we would recommend for initial reporting the following results: HEDIS measures related to the clinical management of cholesterol and the control of high blood pressure, HEDIS measures related to prevention and screening (specifically tobacco use cessation and adult body mass index assessment), and CAHPS composite measures related to customer service and access to needed care. This information should be coupled with consumer-friendly educational information about accreditation and quality measurement and should be presented in an easy-to-understand format that conveys overall plan value (e.g. the NCQA Health Plan Report Card). Consumers should also be informed of how and where they can access patient experience survey results.

Other information available about QHPs could be linked to from the Exchange website, such as links to provider network information, links to state or other government sites about plan, hospital, physician or other providers' quality, and links to other credible non-governmental sites, such as the AHA/ASA's Mission:Lifeline recognition or Get With The Guidelines recognition.

Should these be similar to or different from the Medicare Advantage five-star quality rating system (for example, staying healthy: screenings, tests and vaccines; managing chronic

(long-term) conditions; ratings of health plan responsiveness and care; health plan members complaints and appeals; and health plan customer service)?

There are a number of health plan quality rating programs that CMS could look to as potential models. CMS's Medicare Advantage plan comparison tool and the CHECKBOOK/CSS tool, for instance, both use simple overall quality ratings that consumers can then drill down to get more details for quality and customer service measures of particular importance to them.

When developing or adopting a quality rating system, it will be important that the same underlying measures and methodology be used to the maximum extent possible for QHPs and non- QHP plans so consumers can compare plans inside and outside the Exchange.

11. What are effective ways to display quality ratings that would be meaningful for Exchange consumers and small employers, especially drawing on lessons learned from the public reporting and transparency efforts that states and private entities use to display health care quality information?

Research has indicated that consumers dread shopping for health insurance and therefore look for "short cuts" to help them get through the task.[2] This makes it very important that data be presented by Exchanges in a way that is timely, reliable, and usable for consumers. Regulators should anticipate and leverage this tendency by providing consumers with tested, reliable cognitive short-cuts. Examples might include letter grades indicating health plan quality. Quality ratings should be presented in a clear and concise format, using standardized terminology and descriptions on any Exchange website and in written materials for consumers without Internet access.

The Consumers' CHECKBOOK Center for the Study of Services (CHECKBOOK/CSS), which has more than 30 years of experience providing health plan comparison tools for 8 million federal employees, has developed some helpful best practices that Exchanges should use when displaying health plan information for consumers. They have developed a model health-plan comparison tool that incorporates both information of health plan cost and quality. With respect to plan quality, CHECKBOOK/CSS specifically recommends that the tool include an overall quality rating and then give consumers the ability to drill down for and sort information on various aspects of quality that are of most interest to the user, such as measures specific to health conditions like heart disease or specific aspects of service quality, such as trouble-free claims handling. Types of quality measures that CHECKBOOK/CSS has used in its guide for federal employees and retirees include accreditation status, results of CAHPS surveys, performance on HEDIS measures, information on frequency of disputed claims, and the percentage of the plans' network of providers who are high-rated on selected quality measures.[3]

12. What types of methodological challenges may exist with public reporting of quality data in an Exchange?
Please see our response to question 7.

[2] Quincy L. "What's Behind the Door: Consumers' Difficulties Selecting Health Plans." Consumers Union Health Policy Brief. January 2012. Accessed online at: http://www.consumersunion.org/pub/pdf/Consumer%20Difficulties%20Selecting%20Health%20Plans%20Jan%202012.pdf.
[3] Consumers' CHECKBOOK Center for the Study of Services. "Health Plan Comparison Tools in Exchanges." Accessed online at http://www.checkbook.org/exchange/.

13. Describe any strategies that states are considering to align quality reporting requirements inside and outside the Exchange marketplace, such as creating a quality rating for commercial plans offered in the non-Exchange individual market?
A number of states currently use accreditation, HEDIS and CAHPS as the quality reporting requirements for commercial plans and Medicaid plans at the product level (HMO, POS and PPO). Some of these same commercial plans will be offered as QHPs in the Exchange and will continue to be offered in the non-Exchange individual market.

We also urge HHS to spell out in more detail in future guidance what is possible to encourage health plans to offer high quality care and to encourage consumers to choose the highest value health plans and providers. HHS should set out clear metrics for all quality improvement strategies and Exchanges should hold QHPs accountable for their results — with clear goals and benchmarks — so that consumers and employers will know whether plans are hitting the quality improvement and cost containment targets over time.

14. Are there methods or strategies that should be used to track the quality impact and performance of services for those with accessibility and communication barriers, such as persons with disabilities or limited English proficiency?
Consumer information produced or shared by Exchanges, including quality information, must be comprehensible to the diverse population seeking coverage in the Exchange. Special care should be given to ensure information is understandable to low-income populations that may have little experience purchasing traditional insurance products and to low literacy populations. The ACA also requires that information be presented in a culturally and linguistically appropriate manner for individuals with limited English proficiency and in a manner accessible to individuals with disabilities.

Today accreditation standards are used to try and address this issue. NCQA and URAC have health plan network access and availability process standards that attempt to address this issue by posting information on the accessibility of provider offices or languages spoken to assist members in health plan provider directories available on the websites or in print. The CAHPS survey may also be used to ask questions about member satisfaction with performance of services for those with accessibility and communications barriers. Requiring plans to stratify HEDIS data by available demographic subgroups, such as race, ethnicity, gender or disability status, would help to identify disparities in quality and performance.

15. What factors should HHS consider in designing an approach to calculate health plan value that would be meaningful to consumers? What are potential benefits and limitations of these factors?

In designing an approach to calculate health plan value that is meaningful to consumers, HHS needs to factor in greater transparency on the price and quality of the product that consumers are buying. HHS should ensure that Exchanges are committed to conveying plan price/coverage/quality and consumer experience data in consumer-friendly language, in easily-accessible formats, so that consumers can effectively use the data to make informed purchasing decisions. Standardized benefit forms and the uniform Summary of Benefits and Coverage, along with its Coverage Examples feature, are also important new tools for helping consumers compare the value of health plans.

Little empirical data exists today about what factors consumers consider when shopping for coverage. Anecdotal evidence suggests the premium and whether the consumer's preferred health care provider participates in the plan's network are leading factors when choosing a plan. This

suggests that consumers are often not accustomed to factoring quality information into their decision. In addition, information about the true insurance value of each plan – comparing plans based not just on premiums but also factoring in out-of-pocket costs and tax subsidies for which individuals may be eligible – is critically important for consumers.

Research has also found that consumers using web-based health plan chooser tools make their decisions based on the initial default display of information more than 90 percent of the time.[4] This indicates that basic health plan quality information needs to be readily available in the initial display in order for consumers to consider it.

We strongly recommend that HHS and Exchanges conduct consumer testing to ensure that the display of plan information, including quality ratings, is as effective as possible. Providing meaningful health plan value information that can then be used by consumers to choose high value insurance coverage has the potential to be an important force for quality improvement in the health care system. Competition based on quality can drive plans and providers to produce better outcomes, safer care, and lower costs.

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Thank you again for the opportunity to share our comments on the Request for Information Regarding Health Care Quality for Exchanges. If you have any questions, please feel free to contact Stephanie Mohl, Government Relations Manager, at Stephanie.Mohl@heart.org or 202-785-7909.

Sincerely,

Donna K. Arnett, PhD, BSN, FAHA
President

[4] Consumers Union. "Choice Architecture: Design Decisions that Affect Consumers' Health Plan Choices." July 9, 2012. Accessed online at: http://www.consumersunion.org/pdf/Choice_Architecture_Report.pdf.