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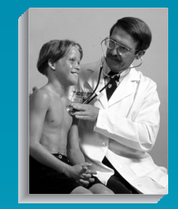
Public Health Service
Agency for Healthcare Research and Quality
2101 East Jefferson Street, Suite 501
Rockville, MD 20852



Annual Report of the National CAHPS® Benchmarking Database 2000

What Consumers Say About the Quality of Their Health Plans and Medical Care

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Prepared for:
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Agency for Healthcare Research and Quality
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Rockville, MD 20852

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Westat

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The Agency for Healthcare Research and Quality (AHRQ) is the lead Federal agency charged with supporting research designed to improve the quality of health care, reduce its cost, address patient safety and medical errors, and broaden access to essential services. AHRQ sponsors and conducts research that provides evidence-based information on health care outcomes; quality; and cost, use, and access. The information helps health care decisionmakers—patients and clinicians, health system leaders, and policymakers—make more informed decisions and improve the quality of health care services. For more information, visit the AHRQ Web site at: www.ahrq.gov

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The National CAHPS® Benchmarking Database (NCBD) is funded by the U.S. Agency for Healthcare Research and Quality and administered by Westat under Contract Number 290-01-0003. For more information, please visit the NCBD Web site (http://ncbd.cahps.org) or contact the CAHPS® Survey Users Network at 1-800-492-9261.

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Message from the Director

It is with great pleasure that the Agency for Healthcare Research and Quality (AHRQ) presents this first annual report of findings from the National CAHPS® Benchmarking Database (NCBD).

When the Agency embarked on the Consumer Assessment of Health Plans (CAHPS®) project in 1995, we set out to develop and test a new, standardized approach for surveying people about their experiences with their health plans and medical care. We also wanted to develop methods for presenting survey findings clearly and fairly to consumers and purchasers for their use in making health plan choices.

Now, 6 years later, we are proud to witness the widespread use of the CAHPS® survey throughout the U.S. health care system. CAHPS® has been adopted by the Medicare program, the Nation's largest purchaser, as well as by growing numbers of State Medicaid agencies and public and private employers. With its inclusion as part of the accreditation program of the National Committee for Quality Assurance, CAHPS® has become the industry standard for use by health plans when seeking accreditation.

The NCBD is a new resource that provides value to CAHPS® survey users by providing national and market-level benchmarks to facilitate comparisons across health plans. It also provides an important source of data for research on consumer assessments of health care of interest to multiple audiences, including policymakers, health plans, providers, purchasers, and consumers.

High-quality comparative data are essential not only to guide choice of health plans, but also for effective quality improvement and research. We extend our thanks to the many thousands of Americans who have helped create this database by responding to the CAHPS® survey, and to the many sponsors who have submitted their survey data to the NCBD. We look forward to continuing to work together to build the NCBD as an integral part of the Agency's commitment to reporting on the quality of the Nation's health care system.

Sincerely,

John Eisenberg, MD

Director, Agency for Healthcare Research and Quality

Executive Summary

The National CAHPS® Benchmarking Database (NCBD) is the national repository for data from the CAHPS® family of surveys. The NCBD was initiated in 1998 to support benchmarking and research related to consumer assessments of care. All sponsors of CAHPS® surveys that are administered according to CAHPS® specifications are invited to participate in the NCBD. Participating sponsors receive a customized report that compares their own results to appropriate benchmarks derived from the NCBD. Survey sponsors include public and private purchasers (employers, State Medicaid agencies, and Medicare) and individual health plans.

Participation in the NCBD is Substantial and Growing

NCBD has experienced tremendous growth during its first 3 years. Participation has grown from 85 health plans to 793 for the adult population and from 33 to 148 plans for the child population. For the adult population, NCBD has grown steadily each year and now includes substantial numbers from all sectors—commercial, Medicaid, and Medicare. For the child population, growth in the Medicaid sector has been steady but participation by the commercial sector declined in 2000 and is expected to remain low until 2002, when a revised survey focusing on children with special health care needs should become more widely implemented.

NCBD is an Important Source of Comparative Information

Examination of NCBD 2000 data has revealed the following key findings:

- Overall, managed care enrollees rate their health care highly and report positive experiences with their care;
- Medicaid, Medicare, and commercial enrollees rate their care differently; and
- Average ratings and reports by enrollees vary across managed care plans.

NCBD is a Valuable Resource for Sponsors

NCBD provides benchmark data through this report and through the Sponsor Reports. Annual evaluations through focus groups, interviews, and surveys have indicated that sponsors are pleased with the process and the reports. Sponsors have indicated they use the data in a variety of ways including evaluating health plan performance, internal management, targeting opportunities for performance improvement, reporting to consumers, and informing policymakers.

NCBD is a Valuable Resource for Researchers

NCBD data are available for researchers who submit an application and sign a data release agreement that ensures the confidentiality of the data. To date, 12 research projects have been approved covering topics from differences in consumer assessments by race and

ethnicity to the effects of case-mix adjustment on reports of patient experiences by health plans' profit status. A complete list of projects, including contact information and current status, is included in this report.

Further information about the NCBD is available through the NCBD Web site at http://ncbd.cahps.org.

NCBD in Future Years

In its first 3 years, NCBD has been established as a valuable source of CAHPS® information for both sponsors and researchers. In the near future, NCBD will also be an important source for the National Healthcare Quality Report (NQR) currently under development by AHRQ. The NQR will be published annually beginning in 2003 and will provide information to policymakers to monitor the Nation's progress toward improved health care quality.

In future years, the NCBD will expand to include new CAHPS®-derived survey data from the following instruments:

- Group-level CAHPS® (G-CAHPS);
- Behavioral Health CAHPS®; and
- Children with Special Health Care Needs.

NCBD staff is also exploring linkages to other datasets to enhance the research value of the data. In the years to come, NCBD will continue to provide valid and reliable data for benchmarking and research related to consumer assessments of care.

About the CAHPS® Survey

In 1995, the Agency for Healthcare Research and Quality (AHRQ) began an initiative to build an integrated set of standardized questionnaires and reporting formats that could be used to collect and report meaningful and reliable information about the experiences of consumers enrolled in health plans. The goals of CAHPS® were to:

1) develop and test questionnaires that assess health plans and services;
2) produce easily understood reports for communicating survey information to consumers; and
3) evaluate the usefulness of these reports for consumers in selecting health care plans and services.

To implement CAHPS®, AHRQ awarded three cooperative agreements to consortia at the Harvard Medical School, Research Triangle Institute, and RAND, and a contract to Westat for user support. In the first stage of the project, the teams designed, tested, and refined the survey instruments, report formats, and accompanying Kit to assist those who use the CAHPS® materials. In the second stage, they implemented and evaluated large-scale demonstration projects and used the results to further refine the CAHPS® materials.

The CAHPS® survey is designed to measure important dimensions of health plan performance from the consumer's point of view. By responding to a standardized set of questions administered through a mail or telephone questionnaire, health plan enrollees report on their experiences and rate their health plans and providers in several areas. CAHPS® surveys are administered to a random sample of health plan enrollees by independent survey vendors, following standardized procedures.

The CAHPS® survey is designed for use with all types of health insurance enrollees (commercial, Medicaid, and Medicare) and across the full range of health care delivery systems from fee-for-service to managed care plans. A core survey questionnaire is available for adults concerning their own experiences and for parents concerning the experiences of their children. Supplemental questions have been developed as modules for people with chronic conditions and special health care needs. Further information on CAHPS® is available through the CAHPS® Survey Users Network Web site at www.cahps-sun.org.

About the NCBD

As CAHPS® was implemented, AHRQ supported the development of the National CAHPS® Benchmarking Database (NCBD) to serve as the repository for all CAHPS® data. All sponsors of CAHPS® surveys that are administered independently according to CAHPS® specifications are invited to participate in the NCBD. Survey sponsors include public and private purchasers (employers, State Medicaid agencies, Medicare) and individual health plans. The NCBD is thus a national database of CAHPS® survey data; it is intended to support

benchmarking and research related to consumer assessments of care.

Initiated in 1998, the NCBD currently includes 3 years of CAHPS® data. The database for 2000 includes CAHPS® survey data from nearly 400,000 survey respondents distributed over more than 900 health plan sampling units. The NCBD is available as a resource for CAHPS® survey sponsors, researchers, and others interested in using comparative CAHPS® survey findings and detailed benchmark data. The NCBD also offers an important source of primary data for conducting specialized research that will enable improvements in future survey design and a better understanding of health plan and enrollee characteristics that influence performance.

Administration of the NCBD

The NCBD is funded by AHRQ and administered by Westat. A formal NCBD Advisory Group, composed of representatives from survey sponsor organizations and other interested groups, provides oversight and direction for the project. A list of NCBD Advisory Group members is included on the inside back cover of this report.

Using the NCBD for Benchmarking

A central purpose of the NCBD is to facilitate comparisons of CAHPS® survey results by survey sponsors. By compiling CAHPS® survey results from a variety of sponsors into a single national database, the NCBD enables purchasers and plans to compare their own results to relevant national benchmarks, in order to identify performance strengths as well as opportunities for improvement.

Survey sponsors may participate in the NCBD simply by submitting their CAHPS® survey results according to specified guidelines. In return, participating sponsors receive a customized report that compares their own results to appropriate benchmarks derived from the NCBD. Comparisons include national averages by population sector and the 90th percentile score for CAHPS® results.

An example of the type of chart used in the NCBD sponsor reports is included in this report, along with information on use of reports by sponsors. As a service to CAHPS® survey sponsors not participating in the NCBD, the appendix to this report includes detailed tables presenting national averages and benchmark data for CAHPS® survey scores in the commercial, Medicaid, and Medicare populations.

Using the NCBD for Research

Researchers may gain authorized access to NCBD data needed to help answer important health services research questions related to consumer assessments of quality as measured by CAHPS®. A list of current NCBD research projects are included in this report.

Organization of This Report

This first annual report of the NCBD includes the following sections:

- **Database Composition—** This section includes detailed information on the NCBD 2000 data, including number of samples, types of plans, and response rates.
- **Summary of Findings—**This section presents key findings by population sector (commercial, Medicaid, and Medicare).
- **Using the NCBD for Benchmarking—**This section describes Sponsor Reports and how sponsors use the data and profiles specific uses of the data.
- **Using the NCBD for Research—** This section describes the research underway using NCBD data.
- **Appendix—**The appendix includes detailed tables presenting national averages and benchmark data for 2000 for CAHPS® survey scores in the commercial, Medicaid, and Medicare populations.

Composition of the NCBD 2000

Overview

The NCBD consists of 3 years of CAHPS® survey data: Phase I in 1998, Phase II in 1999, and Phase III in 2000. As evidenced by the tables below, the number of participating health plans has increased markedly over that time from 85 to 793 for the Adult population. For the Child population, participation has steadily increased among Medicaid plans while commercial plan participation peaked in Phase II (1999).

Data for the Phase I feasibility stage in 1998, shown in Table 1, include CAHPS® 1.0 survey results submitted by 6 commercial and 7 Medicaid sponsors.

Table 1. *NCBD 1998 Composition by Population Sector (CAHPS® 1.0)*

	Adult Population		Child Population	
Population Sector	*Sampling Units**	*Respondents*	*Sampling Units**	*Respondents*
Commercial	54	34,965	0	0
Medicaid	31	23,519	33	9,871
Total	**85**	**58,484**	**33**	**9,871**

Phase II of the NCBD was implemented in 1999 to further develop and demonstrate the feasibility and usefulness of a national comparative database of CAHPS® survey data. Data for Phase II, shown in Table 2, include CAHPS® 2.0 or 2.0H survey results submitted by 15 commercial sponsors and 14 Medicaid sponsors.

Table 2. *NCBD 1999 Composition by Population Sector (CAHPS® 2.0 or 2.0H)*

	Adult Population		Child Population	
Population Sector	*Sampling Units**	*Respondents*	*Sampling Units**	*Respondents*
Commercial	307	168,234	149	42,879
Medicaid	77	28,420	66	14,106
Total	**384**	**196,654**	**215**	**56,985**

**A sampling unit refers to an individual health plan product, such as a Health Maintenance Organization (HMO) or Point of Service (POS) product, whose enrollees are randomly sampled for administering the CAHPS® survey.*

Phase III of the NCBD was conducted in 2000. Data for Phase III, shown in Table 3, include CAHPS® 2.0 or 2.0H survey results submitted by 39 commercial sponsors, 17 Medicaid sponsors, and Medicare.

Table 3. *NCBD 2000 Composition by Population Sector (CAHPS® 2.0 or 2.0H)*

	Adult Population		Child Population	
Population Sector	*Sampling Units**	*Respondents*	*Sampling Units**	*Respondents*
Commercial	270	135,479	8	2,760
Medicaid	156	49,327	140	41,400
Medicare Managed Care	367	166,072	--	--
Total	**793**	**350,878**	**148**	**44,160**

Composition of the 2000 NCBD

Participating Sponsors

All sponsors of CAHPS® surveys that are administered independently according to CAHPS® 2.0 or HEDIS 2.0H specifications are invited to participate in the NCBD. Survey sponsors include public and private purchasers (employers, State Medicaid agencies, Medicare) and individual health plans. Table 4 shows the distribution of sponsors by sponsor type in the NCBD 2000. Readers should note that each sponsor may represent a range of plans or sampling units. For example, individual health plan sponsors account for one health plan within the NCBD, while Medicare managed care (the Centers for Medicare & Medicaid Services [CMS], formerly the Health Care Financing Administration [HCFA],) accounts for 367 plans or sampling units.

Table 4. *Distribution of Sponsors by Sponsor Type*

Sponsor Type	Number of Sponsors
Public Employers	2
Public/Private Purchasing Coalitions	4
Health Plan Coalitions	1
State Medicaid Agencies	14
State Data Agencies	3
Individual Health Plans	32
Medicare Managed Care	1
Total Sponsors	**57**

Health Plan Types

The majority of health plans represented in the NCBD 2000 are HMO plans, as indicated in Table 5.

Table 5. *Health Plan Types by Adult Population Sector*

Plan Type	Commercial	Medicaid	Medicare
Health Maintenance Organization (HMO)	186	146	367
Point of Service (POS)	29	0	0
HMO/POS	36	0	0
Preferred Provider Organization (PPO)	17	0	0
Primary Care Case Management (PCCM)	0	10	0
Indemnity/Fee-for-Service	2	0	0
Total	**270**	**156**	**367**

Response Rates

Response rates vary by population sector in the NCBD 2000, with Medicare health plan enrollees showing the highest rate of response, followed by commercial enrollees and Medicaid enrollees.

Table 6. *Mean Response Rates by Population Sector*

Population Sector	Adult Population (%)	Child Population (%)
Commercial	48.4	41.7
Medicaid	37.6	38.9
Medicare Managed Care	82.0	Not applicable

Representativeness of NCBD 2000 Data

Although the NCBD includes a broad cross-section of commercial, Medicaid, and Medicare health plan enrollees, the extent to which NCBD 2000 data are representative of the general population varies by sector.

- **Medicare:** Survey data for the Medicare managed care population are the most representative of the three sectors. By design, the CAHPS® Medicare Managed Care survey includes all health plans with separate Medicare risk contracts in effect on or before 1996. Because all health plans are included, these survey results are representative of the Medicare

population enrolled in these plans. Moreover, analysis conducted by researchers at Harvard Medical School indicates that the demographics and regional representation of these respondents are similar to the Medicare population as a whole[1].

- **Medicaid:** The NCBD 2000 database includes 14 of the 50 State Medicaid agencies in the United States.[2] In terms of total enrollment, in 1999 these Medicaid programs enrolled 7,813,160 beneficiaries in managed care plans, or roughly 44 percent of the total number of Medicaid managed care enrollees.[3] Within each of the 14 State Medicaid programs participating in the NCBD 2000, the survey data are highly representative of the Medicaid adult and child population enrolled in the Medicaid managed care plans offered in these states.

- **Commercial:** From a geographic perspective, the 270 adult commercial plans in the NCBD 2000 are distributed across 41 states, Guam, Puerto Rico, and Washington, DC. Seventy-three percent of these plans are offered through the Federal Employee Health Benefits Program administered by the U.S. Office of Personnel Management. Data were not available at the time of publication of this report to determine the extent to which the types of plans included in the NCBD 2000 are representative of the mix of plan types in general for the commercial population. Nor was it possible based on the data available to determine the representativeness of survey respondents to the population as a whole.

[1] Bruce E. Landon; Alan M. Zaslavsky; Nancy Dean Beaulieu; James A. Shaul; Paul D. Cleary. "Health Plan Characteristics And Consumers' Assessments Of Quality," Health Affairs *(Volume 20 Number 2) March 2001, pp. 274-286.*

[2] The 14 State Medicaid programs participating in the 2000 NCBD are Arizona, California (San Diego County only), Colorado, Hawaii, Kansas, Michigan, New York, Ohio, Oklahoma, Pennsylvania, Texas, Utah, Vermont, and Washington.

[3] 1999 Medicaid Managed Care Enrollment Report, Health Care Financing Administration.

Composition of the NCBD 2000

In the future, it should be possible to assess the overall representativeness of the NCBD by comparison to CAHPS® results for the general population obtained through the Medical Expenditure Panel Survey (MEPS). MEPS is an annual survey of approximately 15,000 U.S. households sponsored by AHRQ, related to health care cost and utilization behavior. Beginning in 2000, AHRQ has included selected CAHPS® questions in the MEPS survey, thus providing a population-based point of reference for the plan-based CAHPS® data contained in the NCBD.

Database Composition in the Future

The NCBD has become a rich source of data on the CAHPS® survey. It includes data from different population sectors (commercial, Medicaid, and Medicare) and from a variety of plan types including HMO, PPO and primary care case management. As implementation of the CAHPS® survey broadens to include other entities and special population groups (e.g., provider group-level CAHPS®, behavioral health CAHPS®, and children with special health care needs), the NCBD will also expand to include data gathered through these new CAHPS® instruments.

Summary of Findings

In this section, we present selected findings from CAHPS® survey responses collected in 1999 and 2000 by survey sponsors participating in the NCBD. The comparative analyses presented here are not intended to be exhaustive, but rather to illustrate how the NCBD can be used to compare CAHPS® survey results by population sector, survey sponsor, and individual health plan. Detailed tables of benchmark data by sector are provided in the appendix for readers interested in exploring specific comparisons of CAHPS® results.

Comparability of Survey Results Across Population Sectors

Comparing CAHPS® survey results across population sectors requires taking into account the differences that occur in both the data collection field period for the survey and the time frame given to respondents for considering answers to survey questions.

Table 7 compares the range of field periods and response frames across the commercial, Medicaid, and Medicare sectors in 1999 and 2000. It shows that the Medicare survey data collected in the fourth quarter of 1999 are most comparable to the commercial and Medicaid data collected in the first half of 2000. This occurred because of the wider range of field periods for commercial and Medicaid sponsors and the longer (12-month) response frame for commercial survey respondents. The findings presented in this section are based on cross-sector comparisons of 1999 Medicare data and 2000 commercial and Medicaid data.

Table 7. *Correspondence of Survey Field Periods and Response Frames by Sector*

	1999				2000			
Field Periods and Response Frames	*Q1*	*Q2*	*Q3*	*Q4*	*Q1*	*Q2*	*Q3*	*Q4*
1999 Medicare Field Period				■				
1999 Medicare Response Frame (past 6 months)		■	■					
2000 Commercial Field Period					■	■		
2000 Commercial Response Frame (past 12 months)	■	■	■	■	■			
2000 Medicaid Field Period				■	■	■		
2000 Medicaid Response Frame (past 6 months)		■	■	■	■			

Note: The area outlined in bold indicates overlap in response frames for the three sectors.

Figure 1a. Adult Ratings of Personal Doctors

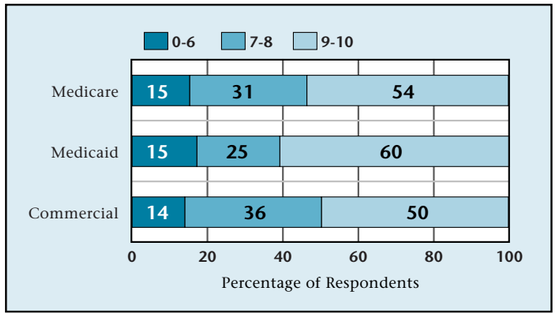
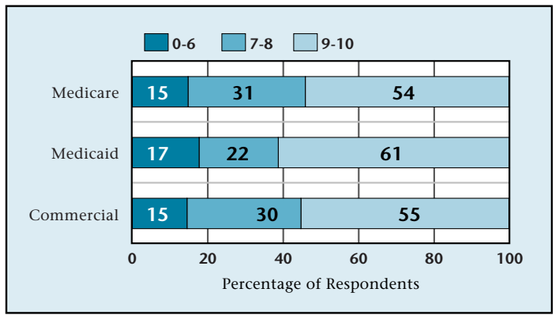


Figure 1b. Adult Ratings of Specialists



Comparability of Survey Results Across Health Plan Model Types

As shown in Table 5 on page 11, the majority of health plans represented in the NCBD 2000 are HMOs. However, the commercial sector data include other health plan types (such as POS and PPO plans) and the Medicaid data include several PCCM models. Since health plan model types may account for some differences in survey results, the cross-sector comparisons presented in this section are based on HMO and POS and HMO/POS combined model types only. Comparing like model types across sectors should make the survey results more comparable.

Consumers' Ratings of Their Experiences With Care

CAHPS® was designed with four ratings to distinguish among important aspects of care. The four questions ask plan enrollees to rate their experiences in the past 12 months with their personal doctor or nurse; the specialist they saw most often; health care received from all doctors and other health providers; and their health plan. Ratings are scored from 0 to 10, where 0 is the "worst possible" and 10 is the "best possible."

Finding #1: Consumers Rate Their Overall Health Care Highly

As shown in Figures 1a through 1d, the majority of survey respondents rate their health plans and medical care highly[4]. For virtually all sectors, close to 50 percent or more of respondents rated their personal doctors, specialists, and overall health care either "9" or "10." However, enrollees across all three sectors provide lower ratings to their health plans; none of the sectors' ratings exceeded 50 percent on this indicator.

Finding #2: Medicare, Medicaid, and Commercial Enrollees Rate Their Care Differently

Although respondents in all three sectors rate their care highly, differences in CAHPS® scores can be observed across commercial, Medicaid, and Medicare plan enrollees. Medicaid enrollees are most likely to rate their providers and plans "9" or "10" compared to Medicare and commercial enrollees. Medicaid enrollees are also most likely to rate their providers and plans in the "0 to 6" range. Medicare enrollees are next most likely to rate providers and plans "9" or "10," followed by commercial enrollees, for all ratings questions except of specialists. There is little difference between the proportion of Medicare and commercial enrollees giving ratings of "0 to 6" except for overall health care, where Medicare enrollees are less likely to give one of the lowest ratings.

Figure 1c. Adult Ratings of All Health Care

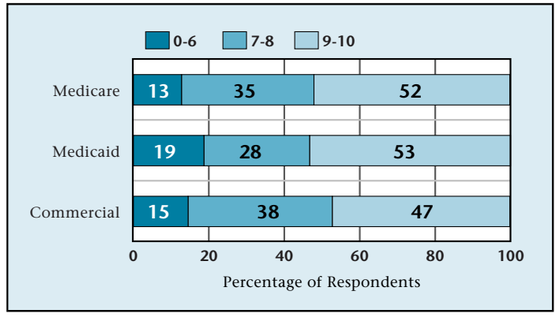
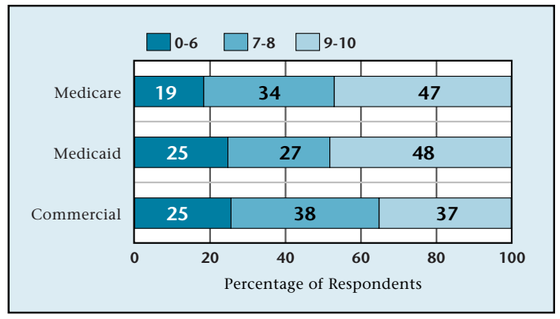


Figure 1d. Adult Ratings of Health Plan



[4] All cross-sector comparisons presented in this report are statistically different at p<01. The statistical tests used adjusted for case-mix differences among health plans in respondent age, education, and self-reported health status.

Consumers' Reports on Their Experiences With Care

CAHPS® was designed to move beyond satisfaction scores (a function of expectations) to more accurate assessments based on "reports" of the patient experience. Much investigation went into the design of questions that capture what constitutes high quality care. Most of the CAHPS® survey questions ask respondents to report on their experiences with different aspects of their care. These reporting questions are combined into groups that address the same aspect of care or service to arrive at a broader assessment. CAHPS® reporting questions fall into five major groups, called composites, that summarize enrollee experiences in the following areas:

- Getting needed care;
- Getting care without long waits;
- How well doctors communicate;
- Courtesy and helpfulness of office staff; and
- Customer service of the health plan.

The reporting questions that make up the "getting needed care" and "customer service" composites ask respondents to indicate how much of a problem the respondent has with a certain aspect of care in the past 12 months: "not a problem," "a small problem," or "a big problem." Results for this composite are reported as the percentage of respondents indicating "not a problem."

The reporting questions that make up the other three composites ask respondents how often something happened in the past 12 months: "never," "sometimes," "usually," or "always." Results for these composites are reported as the percentage of respondents giving the most positive response.

Finding #3: Consumers Report Positive Experiences With Their Care and Medicare Enrollees Report the Most Positive Experiences

As shown in Figures 2a through 2e, 50 to over 80 percent of respondents across all three sectors report the most favorable response possible for the composite questions except for "getting care without long waits." Respondents across all three sectors respond most favorably to "getting needed care." The next most favorable responses correspond to "helpful and courteous office staff," followed by "doctors who communicate well" and "customer service." The lowest scoring composite is "getting care without long waits." In comparing responses by sector within each composite, Medicare enrollees report the most positive experiences for all five composites.

Getting Needed Care includes questions that ask people how much of a problem it is to:

- Find a personal doctor or nurse;
- Get a referral to a specialist that they wanted to see;
- Get the care they or their doctor believed was necessary; and
- Get care approved by the health plan without delays.

Interestingly, although Medicaid enrollees were most likely to answer "9" or "10" for all four of the rating questions shown previously, they provided the lowest score across the three sectors in response to "getting needed care" questions (Figure 2a). The relative report of problems getting needed care across sectors is, however, consistent with the proportion of enrollees giving ratings of "0 to 6" in Figure 1d, the rating of all health care. A similar consistency across sectors occurs between reports of problems in customer service (Figure 2b) and lower ratings of the health plan (Figure 1c).

Customer service is made up of survey questions that asked people how much of a problem they had:

- Getting the help they needed when they called the health plan's customer service;
- Finding the information they needed in the written materials from their health plan; and
- Completing the paperwork for their health plan.

Figure 2a. Adult Reports on Getting Needed Care

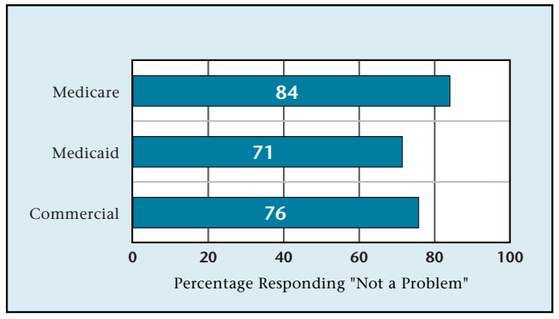


Figure 2b. Adult Reports on Customer Service

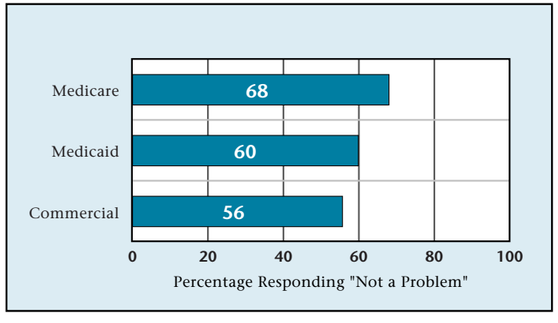


Figure 2c. Adult Reports on Helpfulness of Office Staff

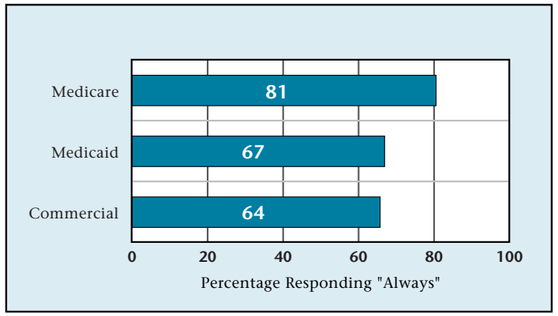


Figure 2d. Adult Reports on Doctors Who Communicate Well

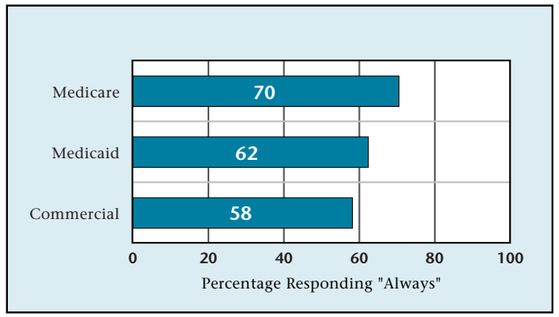
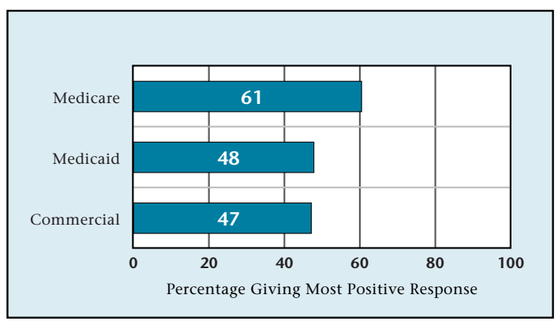


Figure 2e. Adult Reports on Getting Care Without Long Waits



Helpful and courteous office staff includes questions that ask members how often the office staff at their doctor's office:

- Treated them with courtesy and respect; and
- Were as helpful as they should be.

Doctors who communicate well includes questions that ask people how often their doctor or other health provider:

- Listened carefully to them;
- Explained things in a way they could understand;
- Showed respect for what they had to say; and
- Spent enough time with them.

Getting care without long waits includes questions that ask people how often they:

- Got the help or advice they needed when they called the doctor's office during regular business hours;
- Got treatment as soon as they wanted when they were sick or injured;
- Got an appointment as soon as they wanted for regular or routine health care; and
- Waited only 15 minutes or less past their appointment time to see the person they went to see.

Summary of Findings

For the composite reports of experiences with providers (Figures 2c, 2d, and 2e), Medicaid enrollees are much less likely to choose the most positive response than those enrolled in Medicare, and commercial enrollees somewhat less than those in the Medicaid population. These commercial enrollee reports are consistent with their lower ratings of providers (Figures 1a and 1b). The apparent discrepancy between Medicaid enrollees' ratings of providers and their reports of experiences with providers may reflect lower expectations regarding waiting times, provider communication, and helpfulness of office staff compared with other enrollees.

Variation in CAHPS® Scores by Health Plan

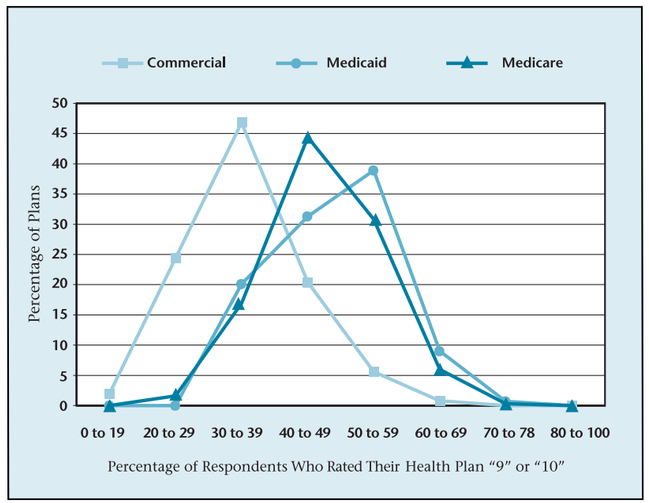
CAHPS® was designed to detect differences among individual health plans in order to help consumers make better choices. In addition to the differences in CAHPS® ratings and composite scores that can be observed across population sectors, major differences exist in CAHPS® scores for individual health plans.

Finding #4: There is Variation in Results Across Individual Health Plans

To illustrate the extent of plan-to-plan variation in CAHPS® scores, Figure 3 presents the distribution of health plans for each of the three sectors by the percentage of each plan's respondents who rated their health plan "9" or "10."

As shown in Figure 3, the percentage of respondents rating their plans "9" or "10" varies significantly across all three sectors. Furthermore, these data clearly demonstrate that consumer assessments of health plan quality are not the same across plans serving the same population sector. For example, approximately one-quarter of the commercial plans had fewer than 30 percent of respondents rate them "9" or "10," while another 26 percent of these plans had 40 percent or more of their respondents assign them the highest ratings. Likewise, almost 20 percent of Medicare plans had fewer than 40 percent of their respondents rate them "9" or "10," while more than a third of Medicare plans had 50 percent or more of their respondents assign them the highest ratings.

Figure 3. Distribution of Plans by Percentage of Respondents Rating Their Health Plan 9 or 10



While the overwhelming majority of plans serving Medicaid enrollees had 40 to 60 percent of respondents rate them "9" or "10," 20 percent of these plans had fewer than 40 percent rate them that highly. Ten percent of plans serving Medicaid enrollees had 60 percent or more of their respondents give them the highest ratings.

These variations in plan-specific scores suggest that plan-level performance information can be an important tool to help guide consumer choice and quality improvement efforts.

Using the NCBD for Benchmarking

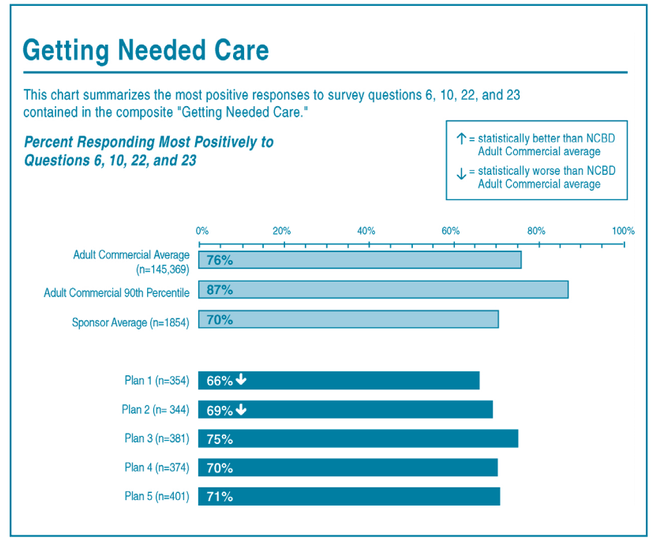
A central purpose of the NCBD is to facilitate comparisons of CAHPS® survey results among various types of CAHPS® survey sponsors, including Medicaid agencies, public and private employers, and individual health plans. These comparisons are intended to provide both purchasers and health plans with benchmarking information useful for evaluating and improving performance as measured by the CAHPS® survey. Benchmarking data are provided through Sponsor Reports and this Annual Report (see appendix).

Sponsor Reports

The primary method for providing benchmarking information is through the Sponsor Reports. Each participating survey sponsor receives a standard sponsor-specific report with results presented at the plan level. This report compares the sponsor's own plan-specific survey results to appropriate benchmarks derived from the NCBD. Comparisons include national averages by population sector and the 90th percentile score for CAHPS® ratings, composites, and individual questions.

An example of a prototypical bar chart used in the NCBD Sponsor Report is shown in Figure 4 for adult survey responses to a selected CAHPS® composite for a hypothetical sponsor with five commercial health plans. The chart compares individual plan scores to the sponsor average (all five plans) and to the national commercial average, as well as to the 90th percentile value. The plan and sponsor results are case-mix adjusted to the national average (on the basis of respondent age, education, and self-reported health status). The arrows show differences that are statistically significant.

Figure 4. Sample NCBD Commercial Sponsor Comparison Chart



Sponsor Reports have evolved over the 3 years of the NCBD based on sponsor feedback. NCBD assesses sponsor feedback annually through focus groups, interviews, and surveys. From these activities, sponsors report using the data for the following purposes.

- Purchaser sponsors use the NCBD data to evaluate health plan performance, by comparing local market or statewide plan performance to national averages and benchmarks.

- Health plan sponsors use the NCBD comparative data for internal management review and to identify target areas and opportunities for improving performance.
- Several sponsors incorporate NCBD data into public reports to educate and inform consumers, policymakers, and other audiences about overall plan performance in the context of the national experience.

Some specific examples of sponsor use of NCBD are presented in text boxes within this section.

Purchaser Use of NCBD Data: The Case of the Washington State Health Care Authority

The Washington State Health Care Authority (HCA) administers programs that provide health care coverage to over half a million State residents, including current and retired public employees and lower income residents not eligible for Medicaid. The HCA conducted CAHPS® surveys in 1997 and 1999 and produced written and electronic reports for State employees to use when making plan choices.

By participating in NCBD, HCA was able to compare the performance of Washington State health plans to the NCBD national commercial average. These comparisons showed that plan performance in the State was often similar to the same plan's performance in the NCBD's cross-market comparisons. For example, 1999 CAHPS® data demonstrated that Washington State plans generally scored low on customer service measures, but that plans overall in the NCBD database also scored low on this measure.

The NCBD data also allowed the HCA to demonstrate that Washington State plans had opportunities for improving their customer service. In 2000, the HCA declared its commitment to improving plan performance on customer service by noting this issue in its annual health plan Request for Proposals. Building on its collaborative relationship with plans, the Agency has expressed its willingness to assist plans with strategies for improving customer service.

Sponsor Support Activities

Ongoing NCBD activities designed to support sponsors in their use of NCBD data include the NCBD Web page at http://ncbd.cahps.org and *NCBD News*, a quarterly electronic newsletter designed to update participating sponsors and others on current activities. NCBD staff have also begun organizing sponsor user groups to allow sponsors to share experiences and learn from others about technical and political issues related to the use of NCBD. NCBD also offers consulting and technical assistance services to sponsors seeking more focused help in using NCBD data analysis and reports to develop and implement improvement plans.

Measuring the Quality of Medical Groups: The Alliance

The Alliance is an employer-owned and directed cooperative in Madison, Wisconsin, that manages health care costs while working with providers to improve the quality of care. The Alliance's quality strategy is to create and sustain a consumer demand for quality. Producing and reporting consumer-friendly information which compares the quality of health care providers is central to this goal.

In 1998, the Alliance took part in a pilot project to adapt the CAHPS® survey for use with physician groups. The adapted CAHPS® questionnaire was then used to assess consumer perceptions of the care provided by the medical groups used most often by Alliance member employees.

As benchmark data, the Alliance selected results from the highest scoring health plans in NCBD and distributed survey results to all members to share with their employees. In addition, the Alliance partnered with local TV stations, the American Association of Retired Persons (AARP), and public libraries to release the information to the general public. The Alliance encouraged consumers to use the report to select a new medical group or to check the performance of the group the consumer currently uses.

The Alliance plans to re-release the survey results during open enrollment and to profile medical groups' activities in response to the results. They also plan to evaluate the distribution and impact of the report through surveys of member employers and their employees.

Using the NCBD for Research

Given the rapid expansion of CAHPS® and the growing interest in consumer assessments of health care, the NCBD provides an important resource to support investigator-initiated research of various kinds. Researchers are invited to submit applications for specific analysis projects to the NCBD Executive Research Committee for review and approval. Applicants must submit a written request with basic information about the research question(s) to be addressed, analyses to be conducted, and a description of products that will result from the research. Upon approval, a data release agreement must be signed committing the researcher to specific procedures for safeguarding the confidentiality of the data.

To date, authorized access to NCBD data files has been granted for all applicants. Findings from selected research projects are described below. This description is followed by a comprehensive list of the 12 investigator-initiated research projects currently underway.

Highlights From Selected Research Projects

Comparing Adult and Child CAHPS® Ratings

Judy Sangl, ScD; Chunliu Zhan, MD, PhD; and Sophia Kazakova, MD of AHRQ's Center for Quality Measurement and Improvement conducted a study comparing adult and child CAHPS® ratings. The researchers wanted to determine whether adult ratings of health plans differed from adult ratings of care for their children. To answer their questions, the researchers analyzed data from commercial and Medicaid plans that had both adult and child CAHPS® results.

The results of their analysis show that the child and adult surveys provide different scores. For Medicaid, all of the (unadjusted) child ratings and composites were higher than the adult results. For commercial plans, child results were higher for all except specialist, customer service, and getting care without long waits. The researchers also found that better health status is strongly associated with higher ratings for both adults and children. When the researchers controlled for health status, the differences between adult and child results decreased. When they controlled for Medicaid, the child results became lower than the adult ratings.

Disparities in Ratings and Reports by Racial and Ethnic Categories

Morales et al. at RAND compared patient ratings from four race/ethnic groups. The researchers found that for the global ratings, whites and other race-ethnic groups gave similar responses. For the composites, the researchers reported that whites tended to report better experiences with care. The study concluded that, when patients are asked to rate their health care, differences between race-ethnic groups are small. When patients are asked to report about specific health care experiences, race-ethnic differences emerge.

Nicole Lurie, MD, MSPH (Medical Advisor Minnesota Department of Health), Principal Deputy Assistant Secretary of Health for the U.S. Department of Health and Human Services and Judy Sangl, ScD and Chunliu Zhan, MD of AHRQ conducted a study of racial and ethnic disparities. The researchers' central question was: Are there racial/ethnic differences in experience with health care and health plans among a commercially insured population as measured by (1) the CAHPS® ratings and reports and (2) consumer reports of access, i.e., having a personal doctor and receiving at least one annual visit? To answer the question, the researchers compared responses from four racial/ethnic categories: Hispanic, white/non-Hispanic, black/non-Hispanic, and Asian.

On the nine CAHPS® global ratings and composite report measures, blacks scored higher on eight of the nine measures while Asians scored lower on seven of the nine measures, compared to whites. Ratings from Hispanics were mixed, with one-third higher, one-third lower, and one-third equal to whites. In terms of consumer reports of access, the study found that whites were more likely to have received one or more office visits and more likely to have a personal doctor than all other groups.

Further examination of certain plans with sufficient sample sizes of minority groups demonstrated that some health plans do a better job than others in assuring access and providing care. The researchers acknowledged that it is not possible to determine if the ratings differences were the result of actual experience, or differences in expectations or measurement response. But the discrepancy between lower access to care for non-whites and the generally higher CAHPS® ratings suggests that lower expectations may play a role.

Twelve Investigator-Initiated NCBD Research Projects

Research Topic	Project Description	Principal Researcher	Current Status
Impact of Race/Ethnicity on Consumer Assessments of Health Care	This analysis examines the relationship between consumer reports and ratings of health plans and the race/ethnicity characteristics of survey respondents.	Ron Hays, PhD UCLA School of Medicine/RAND Corporation (hays@rand.org or 310-794-2294)	Three articles have been published in the July 2001 issue of *Health Services Research* (Vol. 36, No. 3) and one article has been published in *Psychological Assessment* (2001, Vol. 13, No. 2)
Descriptive Results from Parents' Experience of Health Care for Their Children	This study examines results obtained from surveys of parents about their experiences in achieving health care for their children.	Joseph W. Thompson, MD, MPH, AHRQ/University of Arkansas Medical School (thompsonjosephw@exchange.uams.edu or 501-660-7555)	Selected study findings were presented at the 5th National CAHPS® User Group Meeting in October 1999. Two abstracts have been accepted at the Pediatric Academic Societies Annual Meeting in April 2001, with manuscripts to follow.
Psychometric Properties of CAHPS® 2.0 Reporting Composites	This study evaluates the reliability and validity of the CAHPS® 2.0 reporting composites for adult and child data for both Medicaid and commercial populations.	J. Lee Hargraves, PhD Mathematica Research Corporation (lhargraves@hschange.com or 202-484-5261)	Paper submitted for publication in *Medical Care.*
Application of Probabilistic Conjoint Measurement (PCM) Models to CAHPS®	This research project demonstrates the potential that Probabilistic Conjoint Measurement (PCM) models offer for measuring health-related variables derived from the CAHPS® survey.	William P. Fisher, Jr., LSU Health Sciences Center (wfishe@lsumc.edu or 504-568-8083)	Results have been presented at the Third International Outcome Measurement Conference, Rehabilitation Institute of Chicago and the American Public Health Association, Boston.
Analysis of Factors Influencing Variations in CAHPS® Scores	This project analyzes variations in CAHPS® scores and health plan characteristics.	Alan Zaslavsky, PhD Harvard Medical School (zaslavsk@hcp.med.harvard.edu or 617-432-2441)	Several papers on research findings have been drafted and are under review prior to submission for publication.
The Impact of For-Profit, Managed Care Firms on Patient Experiences: Results from the National CAHPS® Benchmarking Database	This project compares CAHPS® results between enrollees in investor-owned and not-for-profit HMOs.	Michael Manocchia, PhD Health and Addictions Research, Inc. (mmanocchia@har.org or 617-266-9219 ext. 105)	This study is still in progress.
Comparison of TRICARE and NCBD Data on Common CAHPS® Items	This analysis compares responses of Department of Defense beneficiaries receiving their health care from TRICARE with individuals represented in the NCBD database on common CAHPS® items.	Peter H. Stoloff, (stoloffp@cna.org or 703-824-2244)	Results of this evaluation available in a report entitled, "Evaluation of the TRICARE Program: FY2000 Report to Congress."

Continued on next page.

Twelve Investigator-Initiated NCBD Research Projects (continued)

Research Topic	Project Description	Principal Researcher	Current Status
Comparison of CAHPS® Adult Survey Results with CAHPS® Child Survey Results	This project determines if there are differences in member satisfaction ratings between adults for their own care and adults' opinion of their experiences with their children's care.	Judy Sangl, ScD AHRQ (sangl@ahrq.gov or 301-594-1702)	Additional analyses are being conducted, and a manuscript was be submitted to a journal for publication in March 2001.
Implications of (Mis-) Using the CAHPS® Star Charts for Comparing Individual Health Plans	This project is investigating the implications of (mis-) using the CAHPS® "star charts" to compare individual plans with each other rather than against the average of the plan means.	Scott Scheffler, M.Ap.St., Research Triangle Institute (sscheffler@rti.org or 919-541-5923)	This study is still in progress.
Case-Mix Adjustment of CAHPS® 2.0 Reporting Composites	This is evaluating different case-mix models for adjusting plan level scores based on the children's version of CAHPS® 2.0.	Elizabeth R. Woods, MD, MPH, Harvard Medical School (elizabeth.woods@tch.harvard.edu or 617-355-6495)	This study is still in progress.
Racial/Ethnic Differences in Experience With Health Care and Health Plans Among a Commercially Insured Population	This study will investigate differences in member satisfaction ratings and reports among different racial and ethnic groups across all plans and within different plans. The study will also determine whether there are differences in self-reported access by racial and ethnic groups.	Judy Sangl, ScD AHRQ (sangl@ahrq.gov or 301-594-1702)	This study is still in progress.
Benchmarking Statistics from the Health Care Survey of Department of Defense Beneficiaries (HCSDB)	This study will compare six CAHPS® composites to composite scores constructed from an annual survey of the military health system.	Eric Schone, Mathematica Policy Research, Inc. (eschone@mathematica-mpr.com or 202-484-4839)	This study is still in progress.

Appendix: Detailed NCBD 2000 Benchmark Tables by Sector

The tables in this appendix present detailed NCBD 2000 scores for CAHPS® composites and rating questions that are reported as core results in standard NCBD Sponsor Reports. Separate tables are presented for the following data sets comprising the NCBD 2000.

- Benchmark Table 1(A-B): Adult Commercial
- Benchmark Table 2(A-B): Adult Medicaid
- Benchmark Table 3(A-B): Child Commercial
- Benchmark Table 4(A-B): Child Medicaid
- Benchmark Table 5(A-B): Medicare Managed Care

All benchmark tables include results for HMO or POS plans only. The adult and child commercial benchmark tables do not include data from PPOs or fee-for-service plans and adult and child Medicaid benchmark tables do not include data from PCCM plans.

Part A in each table presents the composite scores for the five composites reported in standard NCBD sponsor reports. The NCBD Average for each composite represents the mean score of those giving the most positive response across all respondents in that population sector. The lowest plan score and highest plan score represent the lowest and highest scores, respectively, among all health plans represented in that population sector.

The highest and lowest plan scores for each of the five composites reflect case-mix adjusted scores. Age (of the respondent), health status, and education were used as case-mix adjusters to calculate the highest and lowest adult commercial and adult Medicaid plan scores. The parent/-guardian's age and education, and child's health status were used to adjust the highest and lowest child commercial and child Medicaid plan scores.

Plans that did not provide respondent level data on these variables were dropped from the calculation of the highest and lowest scores. However, they were included in calculating the NCBD average.

Part B in each table contains benchmarks for the four individual rating questions from the CAHPS® survey. For each rating, the NCBD average indicates the proportion or percentage of individual responses in each of three collapsed response categories (0 to 6, 7 to 8, and 9 to 10) across all respondents in that population sector. Again, the lowest and highest plan scores represent the lowest and highest proportions, respectively, among all health plans represented in that population sector.

The highest and lowest plan scores for each of the ratings were not case-mix adjusted.

As shown in Table 7 on page 15, most Medicaid plans conducted their CAHPS® studies in the first half of 2000. A few Medicaid plans that did not conduct their CAHPS® Child surveys during this time period were dropped from the NCBD average and from the calculation of the highest and lowest plan scores.

Note: The percentages across all response categories for rating questions may not always add to 100 percent due to rounding error.

Benchmark Table 1 (A-B): Adult Commercial

Table 1A. *Composite Scores*

Composite:	Percentage Giving the Most Positive Response: NCBD Average	Lowest Plan Score	Highest Plan Score
Getting Needed Care	76	54	95
Getting Care Without Long Waits	47	30	63
Doctors Who Communicate Well	58	44	72
Courteous Office Staff	64	48	75
Customer Service	56	27	74

Table 1B. *Patients' Ratings of Their Care Experience*

(On a scale of 0 to 10, where 10 is "best possible" and 0 is "worst possible")

Ratings Questions:	Scale	Percentage Giving the Most Positive Response: NCBD Average	Lowest Plan Score	Highest Plan Score
Q8 Rating of Personal Doctor				
	9 to 10	50	36	81
	7 to 8	36	17	46
	0 to 6	14	2	26
Q12 Rating of Specialist				
	9 to 10	55	38	74
	7 to 8	30	22	45
	0 to 6	15	4	28
Q31 Rating of All Health Care				
	9 to 10	47	28	74
	7 to 8	38	22	46
	0 to 6	15	4	34
Q38 Rating of Health Insurance Plan				
	9 to 10	37	16	69
	7 to 8	38	21	49
	0 to 6	25	8	54

Appendix: Detailed NCBD 2000 Benchmark Tables by Sector

Benchmark Table 2 (A-B): Adult Medicaid

Table 2A. *Composite Scores*

Composite:	Percentage Giving the Most Positive Response: NCBD Average	Lowest Plan Score	Highest Plan Score
Getting Needed Care	71	51	90
Getting Care Without Long Waits	48	30	71
Doctors Who Communicate Well	62	51	89
Courteous Office Staff	67	47	91
Customer Service	60	39	80

Table 2B. *Patients' Ratings of Their Care Experience*

(On a scale of 0 to 10, where 10 is "best possible" and 0 is "worst possible")

Ratings Questions:	Scale	Percentage Giving the Most Positive Response: NCBD Average	Lowest Plan Score	Highest Plan Score
Q6 Rating of Personal Doctor				
	9 to 10	60	39	77
	7 to 8	25	14	42
	0 to 6	15	2	27
Q10 Rating of Specialist				
	9 to 10	61	38	80
	7 to 8	22	3	39
	0 to 6	17	0	42
Q30 Rating of All Health Care				
	9 to 10	53	35	68
	7 to 8	28	15	49
	0 to 6	19	5	36
Q45 Rating of Health Insurance Plan				
	9 to 10	48	30	70
	7 to 8	27	12	40
	0 to 6	25	8	49

Benchmark Table 3 (A-B): Child Commercial

Table 3A. *Composite Scores*

Composite:	Percentage Giving the Most Positive Response: *NCBD Average*	*Lowest Plan Score*	*Highest Plan Score*
Getting Needed Care	83	72	91
Getting Care Without Long Waits	56	41	64
Doctors Who Communicate Well	70	61	78
Courteous Office Staff	74	64	84
Customer Service	61	42	74

Table 3B. *Patients' Ratings of Their Care Experience*

(On a scale of 0 to 10, where 10 is "best possible" and 0 is "worst possible")

Ratings Questions:	*Scale*	Percentage Giving the Most Positive Response: *NCBD Average*	*Lowest Plan Score*	*Highest Plan Score*
Q9 Rating of Personal Doctor				
	9 to 10	61	54	67
	7 to 8	30	26	34
	0 to 6	9	4	18
Q13 Rating of Specialist				
	9 to 10	56	49	65
	7 to 8	29	22	33
	0 to 6	15	6	22
Q34 Rating of All Health Care				
	9 to 10	59	39	67
	7 to 8	31	25	39
	0 to 6	10	3	22
Q41 Rating of Health Insurance Plan				
	9 to 10	48	30	62
	7 to 8	35	30	42
	0 to 6	17	6	40

Benchmark Table 4 (A-B): Child Medicaid

Table 4A. *Composite Scores*

Composite:	Percentage Giving the Most Positive Response: *NCBD Average*	*Lowest Plan Score*	*Highest Plan Score*
Getting Needed Care	76	45	92
Getting Care Without Long Waits	53	38	70
Doctors Who Communicate Well	68	49	86
Courteous Office Staff	70	53	88
Customer Service	64	37	89

Table 4B. *Patients' Ratings of Their Care Experience*

(On a scale of 0 to 10, where 10 is "best possible" and 0 is "worst possible")

Ratings Questions:	*Scale*	Percentage Giving the Most Positive Response: *NCBD Average*	*Lowest Plan Score*	*Highest Plan Score*
Q7 Rating of Personal Doctor				
	9 to 10	56	8	78
	7 to 8	25	12	35
	0 to 6	19	1	77
Q11 Rating of Specialist				
	9 to 10	61	35	88
	7 to 8	23	0	39
	0 to 6	16	0	38
Q34 Rating of All Health Care				
	9 to 10	63	40	79
	7 to 8	25	7	40
	0 to 6	12	0	35
Q55 Rating of Health Insurance Plan				
	9 to 10	56	33	75
	7 to 8	27	16	35
	0 to 6	18	6	44

Benchmark Table 5 (A-B): Medicare Managed Care

Table 5A. *Composite Scores*

Composite:	Percentage Giving the Most Positive Response: *NCBD Average*	*Lowest Plan Score*	*Highest Plan Score*
Getting Needed Care	84	65	96
Getting Care Without Long Waits	61	33	75
Doctors Who Communicate Well	70	49	84
Courteous Office Staff	81	49	90
Customer Service	68	20	89

Table 5B. *Patients' Ratings of Their Care Experience*

(On a scale of 0 to 10, where 10 is "best possible" and 0 is "worst possible")

Ratings Questions:	*Scale*	Percentage Giving the Most Positive Response: *NCBD Average*	*Lowest Plan Score*	*Highest Plan Score*
Q13 Rating of Personal Doctor				
	9 to 10	54	25	73
	7 to 8	31	20	50
	0 to 6	15	6	33
Q17 Rating of Specialist				
	9 to 10	54	21	71
	7 to 8	31	9	54
	0 to 6	15	6	55
Q36 Rating of All Health Care				
	9 to 10	52	25	69
	7 to 8	35	16	50
	0 to 6	13	5	29
Q56 Rating of Health Insurance Plan				
	9 to 10	47	24	74
	7 to 8	34	18	48
	0 to 6	19	5	46

Appendix: NCBD Advisory Group Members

Diane Bechel, DrPH
National Director
3 Automaker/AHA Hospital Profiling Project

Abby Block, MBA, MSW, MA
Assistant Director, Insurance Program
Office of Personnel Management

Rachel Block
Center for Medicaid and State Operations
Centers for Medicare & Medicaid Services

Becky Cherney
President and CEO
Central Florida Health Care Coalition

Paul Cleary, PhD
Professor of Health Care Policy
Harvard Medical School

Christine Crofton, PhD
Health Science Administrator
Agency for Healthcare Research and Quality

Charles Darby, MA
Health Science Administrator
Agency for Healthcare Research and Quality

Arnold Epstein, MD, MA
Chair, Department of Health Policy and Management
Harvard School of Public Health

Elizabeth Goldstein, PhD
Director, Division of Beneficiary Analysis
Centers for Medicare & Medicaid Services

Lauren Harris-Kojetin, PhD
Senior Health Researcher
Research Triangle Institute

Ron Hays, PhD
Professor of Medicine
UCLA School of Medicine/RAND

Jim Lubalin, PhD
Lubalin Consulting

Darendia McCauley, PhD
Director of Quality Assurance
Oklahoma Health Care Authority

Phyllis Torda, MA
Vice President, Policy and Product Development
National Committee for Quality Assurance

Mary Uyeda, PhD
Director, Health Information and Program Evaluation
Washington State Health Care Authority

Thomas Williams, LTC
Director of Program Evaluation, TRICARE Management Activity
Department of Defense