What Performance Measures Do Consumers Find Useful When Selecting Marketplace Health Plans?

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ABSTRACT

OBJECTIVES: As the marketplaces prepare to report mandatory health plan quality information in the 2018 season, it is critical to explore what consumers view as crucial when choosing a health plan.

STUDY DESIGN: Four focus groups were selected from marketplace plans and from the uninsured to cover 4 populations: 1) healthy and aged 18 to 34 years (young), 2) healthy and aged 35-64 years, 3) aged 18 to 64 years with at least 1 chronic condition, and 4) aged 18 to 64 years with low income.

METHODS: Within the focus groups, we explored consumers' ability to use measures from eValue8, the leading tool that large employers use to compare and select health plans.

RESULTS: We found that consumers have different views of health plan measures compared with employers. First, consumers care most about measures indicating how well plans support long-term patient–physician relationships—many plan measures were seen to be intrusive in this relationship. Second, consumer distrust of health plans made them skeptical of many value-based purchasing measures preferred by employers, such as rewarding providers for high quality. Consumers do not like plans interfering with medical care.

CONCLUSIONS: Overall, new types of measures are needed to enable consumers to make an informed health plan selection in the marketplaces.

By July 2015, 7.2 million consumers had purchased coverage through the 37 federally facilitated marketplaces and federally supported state-based marketplaces, and 2.7 million purchased coverage through the remaining state-based marketplaces.[1] For many of these consumers, choosing a health plan can be a daunting task, especially since most of the marketplaces offer a wide array of plan choices. For example, in the 2016 Maryland Health Connection, each county offers a 40-year-old enrollee a choice between 31 and 49 health plans provided by 5 carriers.[2]

To aid consumers, all marketplace websites are required to start providing consumers with plan quality ratings during the enrollment period for 2018 coverage.[3] These ratings will come from plan data submitted to the federal Quality Reporting System (QRS), which, in 2016, will report 1 aggregate star rating for each carrier's plan type, based on 31 clinical measures and patient experience measures.[4,5] Although the QRS serves as a base of important performance measures for the marketplaces, many state-based marketplaces may also desire to report on a broader set of performance measures, as 9 states did in 2014.[6]

The vast number of available detailed measures raises the question of what consumers need in order to best compare health plans. Historically, employers develop health plan choices for employees, and many large employers are experienced in selecting measures for the comparison of health plans. One prime example is the National Business Coalition on Health (NBCH), which represents over 4000 employers and approximately 35 million employees and their dependents.[7] Working with large healthcare purchasers, such as Marriott

and General Motors, the NBCH has collected a large set of health plan performance measures to help employers develop the choice of health plans for their employees. This set of measures, known as eValue8 (eV8), has hundreds of detailed plan measures to guide employers in making wise, value-based purchasing decisions, and to save their employees from having to digest a lot of the complicated business and medical details needed to compare plans.[8]

There is a debate over what would be an optimal set of performance measures that consumers could reasonably use on their own to compare health plans if such large employers were not serving as intermediaries in the marketplaces. To address this issue, we take a first step in this paper by reporting on the Agency for Healthcare Research and Quality's (AHRQ) research results from focus groups of marketplace consumers and the uninsured to assess what information they would want to know when comparing health plans. In particular, various employer eV8 plan performance measures were tested for use among consumers. We highlight how large employers and marketplace consumers have differing perspectives on the healthcare system and how this may impact health plan comparisons. Overall, our results may help bridge this gap in terms of transforming sophisticated performance measures from a purchaser-centric use to a very consumer-centered focus in the marketplaces.

METHODS

Study Population

We worked with 2 firms to recruit participants in the Baltimore, Maryland, and Raleigh, North Carolina, areas. All participants either 1) had purchased a health insurance plan through their local marketplace during the 2013 to 2014 open enrollment season, or 2) were currently uninsured. Four target populations were selected to reflect the marketplace enrollees' traditionally hard-to-reach populations, as well as a diverse marketplace risk pool[9]: 1) young (aged 18-34 years) and healthy (must not have been diagnosed with any chronic health condition), 2) healthy and aged 35 to 64 years; 3) adults aged 18 to 64 years with at least 1 chronic condition, and 4) adults aged 18 to 64 years with low income. See **Table 1** for sample demographics.

Table 1. Demographics of Participants From All Focus Groups

DEMOGRAPHICS	MEAN
Gender	
Female	53%
Male	47%
Insurance status	
Insured through marketplace	72%
Uninsured	28%
Age, years	
18-34	39%
35-64	61%
Race	
African American	31%
Asian	5%
More than 1 race	3%
White	58%
Other	3%
Ethnicity	
Hispanic/Latino	8%
Non-Hispanic/Latino	92%
Household income	
<$20,000	22%
$20,000-$60,000	67%
$60,000-$100,000	8%
$100,000	3%
Education	
High school or GED	20%
Some college	25%
2-year degree	8%
Vocational school	3%
4-year degree	36%
Postgraduate	8%
Chronic conditions	
1 or more	42%
None	58%

Materials for Testing

We selected and organized the 2014 eV8 measures in a way that could be understandable to consumers. Out of 280 eV8 measures, 237 were selected for inclusion based on systematic evaluation of the relevance and possible use in consumer health plan decision making. Along with these eV8 measures, we included additional topics that might help consumers select a health plan. To reduce the amount of information needed to be processed by consumers, individual measures and topics were organized into domains. The domains were then grouped by theme into the following 7 modules for focus group testing: 1) providing customer service and information about the health plan, 2) rewarding doctors and hospitals that provide the best care, 3) helping members get the care they need, 4) supporting communication about members' care across different providers, 5) helping members prevent and manage health issues, 6) helping members make decisions based on quality and cost, and 7) helping members get the right care at the right time. The development of the displays for each module and domain was based on the principle of plain language to generate consumer-friendly labels.[10]

Focus Groups

We conducted 4 focus group discussions, with a total of 36 partic-

ipants. The moderator first asked the participants to explain what a health plan is in their own words, what the health plans do, and how they might evaluate health plans. Next, the moderator presented a short overview about quality measurement in general and the eV8 measures specifically. The moderator explained how this information may be used to help individuals to select health plans. Subsequently, participants reviewed a summary page with ratings for all 7 modules being tested. They were asked what the display told them about the health plans, their understanding and interpretation of consumer-friendly labels and quality rating display, and which 3 modules were most important.

After viewing the summary page with all 7 modules, the participants were asked to look at detailed display ratings for the domains under the selected modules. The participants were again asked what the more detailed displays told them about the health plans, their understanding and interpretation of the domains within each module, whether each domain fit within the module, the importance of each domain, and whether any topics were missing from the module. After reviewing 1 or 2 modules in depth, the participants revisited the overall list of modules to see if any changed their mind about the interpretation or importance of the modules.

RESULTS

Table 2 shows what consumers voted as the top 3 modules that they thought were most important in choosing a health plan. The order of the rankings breaks into 3 distinct groups: Costs and Quality, Access and Quality, and Quality Incentives. The module that addressed Costs and Quality had the highest ranking, with 75% of the consumers agreeing that the module, "Helping members make decisions based on quality and cost," was among the 3 modules most important in choosing a plan. The second group of important modules addressed the concept of Access and Quality: "Helping members get the care they need" (61%), "Helping members prevent and manage health issues" (56%), and "Providing customer service and information about the health plan" (56%). Finally, the modules that focused on Quality Incentives received the least amount of votes, and included "Supporting communication about members' care across different providers" (31%), "Helping members get the right care at the right time" (17%), and "Rewarding doctors and hospitals that provide the best care" (3%).

To understand these rankings, we performed deep dives within the focus groups. Not surprisingly, participants from each focus group agreed that cost is the deciding factor: "it all comes down to cost." This is well known in the literature[11-16]; however, what is new here is that we observed 2 surprising implications of the consumers' struggle to manage high out-of-pocket costs. First, we found that consumers view the selection of a health plan as a "long-term investment" in their healthcare that protects them from large, unexpected healthcare bills and as supporting the physician–patient relationship. Second, because overall healthcare costs are so persistently high and viewed by some consumers as being the result of profit-taking in the healthcare industry, a segment of consumers have a "deep distrust" in health plans and any type of incentive scheme to improve quality. For these participants, incentives are just an added cost that they end up paying for without sharing in the cost savings. These 2 contrasting concepts—long-term investment motives and deep distrust—influence how consumers view measures of health plan performance.

DISCUSSION

Measures That Enable Long-Term Patient–Physician Relationships

What do consumers think they are investing in for the long run through a health plan? Many are seeking a long-term personal relationship with a physician; the uninsured and marketplace consumers are not interested only in catastrophic plans. Here, when consumers voted for the top 3 of 8 domains of interest in the module "Helping members prevent and manage health issues," they voted overwhelmingly for the domain "Members get the care they need for their long-lasting health problems" (89%) compared with the low-scoring catastrophic care measure domain, "Members get the health services and support for major life events" (33%). Costs seem to be a driving factor in this ranking. As one participant noted, premiums for catastrophic plans are nowadays just as expensive as regular health plans. Another participant mentioned that one saves money in the long run by focusing on long-term health needs and prevention. Some consumers had specific experiences with this issue, with one noting that his past catastrophic plan would pay for a leg amputation for diabetes, but not cover his long-term use of an insulin pump.

The only domain out of all the modules that received a 100% vote as being important was for "Members can easily get appointments with in-network doctors." Once they can see a physician, many want to establish a long-term relationship. One of the biggest fears is that the health plan will not keep their physician, and this was one of the suggestions for a new measure missing from eV8: "How long does the physician stay with the plan? Are physicians happy with the health plan?" Many consumers referred to this as "longevity." As one participant remarked, "I don't want to find a new doctor because the insurance company says they no longer have contact with my physician. It's not an attitude I appreciate." Some consumers believed doctors leave plans that do not reimbursement them promptly. This contributed to the new domain of measures that we added as part of testing—"Health plan processes payments and handles payment issues quickly and correctly"—and was rated by 78% as among the top 3 domains in the Customer Service module, along with the domain "Members stay with the plan over time" (78%). As one participant framed the issue, "I have a good relationship with my doctor, and I want to make sure that the person I'm paying money to every month is treating my doctor the way he should be

Table 2. Consumers' Top Ratings of Modules[a] of Health Plan Performance Measures Most Important in Choosing a Plan

	PERCENT RATING THIS AS AMONG THE TOP 3 PERFORMANCE MEASURE MODULES[b]
Domain: Costs and Quality	
Helping members make decisions based on quality and cost Members get information to help choose among treatment options Members say they discuss treatment options with doctors Members say they can find information on costs of care and medicines Members have cost and quality information to help choose doctors Members have cost and quality information to help choose hospitals	75%
Domain: Access and Quality	
Members get the care they need Members say they get timely appointments and care Members have access to the doctors and pharmacies they prefer Members can easily get appointments with in-network doctors Members get mental health services when needed Members get services that meet their language and cultural needs	61%
Providing customer service and information about the plan Health plan processes payments and handles issues quickly and correctly Members' rating of their health plan Members get timely and helpful customer service Members get up-to-date information about health plan services Members stay with the plan over time	56%
Helping members prevent and manage health issues Members' rating of their healthcare Members' rating of their doctor Members get the care they need to stay healthy Members get the health services and support for major life events Members get the care they need for their long-lasting health problems Members' children with long-lasting conditions get the care they need Members get the care they need for mental health Health plan supports hospitals' efforts to prevent complications	56%
Domain: Quality Incentives	
Supporting communication about members' care across different providers Plan offers services from doctors who do a good job of coordinating care Member discounts for using doctors who do a good job of coordinating care Health plan promotes the use of electronic medical records to improve communication about care	31%
Helping members get the right care at the right time[c] Members get treatments they need and avoid treatments they do not need Members get safe and affordable prescription drugs when needed	17%
Rewarding doctors and hospital that provide the best care Health plan pays more to doctors, hospitals, and other providers who offer high-quality, affordable care	3%

[a]In each of the 7 modules and their domains, consumers were shown 1 example of how the individual eValue8 quality measures were "wrapped up" into a domain topic. Consumers voted for their top 3 modules as being the most important ones in choosing a health plan.

[b]The right column shows the percentage of consumers voting that module as one of their top 3 choices (column adds up to 300% after accounting for rounding).

[c]Two of the 4 groups did not vote on "Helping members get the right care at the right time" because participants had difficulty distinguishing it from "Helping members get the care they need."

Source: Authors' analysis.

treated." In fact, many participants requested to look at 10 years of plan measure data (instead of 3 years) to get a better picture of the longevity of the plan. One participant concluded, "When people are satisfied, it takes 20 years to build the loyalty and customer service base and it takes 5 minutes to lose it. It's a proven track record. Something is going right."

The goal of establishing a long-term relationship with a physician may have contributed to some consumers having a surprisingly negative view of some other health plan measures. The crux is that these participants do not want the health plans to intrude into their physician–patient relationship and their medical care. For example, in the Cost and Quality module, consumers liked the shared decision-making domain when it pertained to the physicians helping them, but not when it involved help from the health plans; that domain, "Members get information to help choose among treatment options," scored the lowest. As one participant described, "It says it can help choose among treatment options. The doctor told us to do this, this, and this. Pay for it. It doesn't involve you. Why is the health insurance company helping me choose treatment options? I'm uncomfortable with them doing it." Another participant agreed, "Treatment options are confidential. The health plan shouldn't know about what disease I have or what treatment I am getting, etc. They should just pay for it." Clearly, another participant saw the health plan as an intrusion, "The insurance company is going to influence what is best for them. The insurance company is not on my side. The doctor is on my side."

This was a frequent refrain among consumers, that the physician is the medical expert. Any attempt by the health plan to interfere with their physician's recommendations for treatment is an intrusion. All the consumers need is a long-term relationship with the doctor and he or she will give them the appropriate treatment specific to their illness. Describing the role of the health plan in treatments, one participant said, "They pay for it. Nothing else. The plan is a conduit for money. Healthcare is performed by doctors, nurses, etc. I don't need them to do anything else other than what I pay for them for, which is to reimburse the doctors for their treatment decisions." Thus, overall, consumers are not really comfortable with measures that delve into topics that they believe are best left to their physician.

Distrust in Measures That Enable Incentives

Although most of the policy world is engaged in efforts to move US healthcare to a value-based payment system, we find many consumers are skeptical of value-based incentives. As seen in Table 2, this module scored the lowest in terms of what consumers thought they needed to know about a plan to make a choice. When we drilled deeper into this module, however, we found that consumers were quite negative about health plans designing provider incentives. Looking at the module, "Rewarding doctors and hospital that provide the best care," we found that some participants felt that hospitals and doctors already get paid enough and should not be getting more money, with one participant explaining, "I have a serious issue for rewarding doctors for what they already charge. They make 6 figures already, they don't need a bonus." In response, a few participants noted that it was not unusual for individuals or companies to be rewarded for doing a good job, "but maybe it's because it's healthcare and there are already so many costs associated with it," that people are not as open to rewarding doctors and hospitals. Another participant added, "What is the reward? Are they being rewarded for showing up and doing their job? I was a teacher for 10 years and I didn't get a reward for showing up to work every day and teaching my classes. The problem with bonus plans is that results can be fudged. You're motivating people to cheat. It's the same with health insurance. If doctors are being rewarded for the best care, who is determining what the 'best care' is? Is the best care not costing the insurance company money?"

Others worried about rewarding providers for making healthcare affordable. One participant stated, "One of the big fears is that saving the insurance company money will lead to worse outcomes for patients." Another asked, "Who is it affordable for? The insurance company or for me? Is this saying that the doctor asked for 15 different tests instead of 1? Or is it saying that because he didn't ask for any tests, he's just that good and knows exactly what is wrong with you?" Similarly, one participant inquired, "Where is the money coming from for these rewards? Is it coming from us? I need more information to say it's great."

Patients were equally dismayed with quality incentives under the domain, "Members get treatments they need and avoid treatments they do not need." There is concern over why and how the health plan can determine overuse. One participant commented, "I think this is something you talk to your doctor about. Not the health insurance plan." Another asked, "How do they avoid treatments that patients didn't need? How did they make that determination?" Another responded, "I'm not comfortable with them rejecting something that a doctor recommends."

CONCLUSIONS

Our focus group findings are much like the focus group results recently revealed by Sommers et al (2013): consumers have a great deal of antagonism toward insurers.[17] They found that this antagonism colored consumer's discussions with providers about costs of treatment. Here, we find a much broader effect of this antagonism in terms of leading consumers to view many important health plan performance measures with skepticism. Many new measures that we, as policy makers and employers, see as very important in order to move the US healthcare system toward a value-based payment system, consumers view as being of little importance in the marketplace. This result is different than that found by Hibbard and Jewett, who found consumers view measures as unimportant if they cannot understand them.[18] Whether they be measures of rewarding providers for high quality, or measures of overuse—as

those recently formulated by the Choosing Wisely Campaign[19]—consumers react very negatively. Although eV8 has been used by employers to successfully measure these value-based incentives, eV8 and employers have been less concentrated on measuring the patient–physician relationship. Employers have tended to focus more on measures of health plans' arms-length relationship with physicians, measuring concepts such as the types of contracts and incentives that health plans have with physicians. However, our focus groups have clearly demonstrated that consumers care more about measures indicating how well health plans support long term patient–physician relationships.

The problem of consumers' inability to understand value-based incentives and rewards for high-quality care illustrates the need for consumer education and a better understanding of how to present these measures to consumers. It will require additional research on strategies to best display this information before many of the measures we examined in this paper can be successfully used by consumers. However, whether this is feasible and cost-effective in the marketplaces is debatable. Given these barriers to consumers using measures to compare plans, 4 of the state marketplaces have attempted to serve as intermediaries in the 2014 marketplaces, engaging in selective contracting. This is much like what large employers do using eV8: examine the performance measures themselves to select health plans for their consumer population. Future research should examine the effectiveness of using selective contracting in combination with consumer quality reporting in the marketplaces. This need for both consumer protections, combined with quality reporting, was noted much earlier in the Clinton Health Care Reform in order to make managed competition work.[20]

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