

The Effects of Out-of-Pocket Costs on Enrollees' Experiences With Health Plans: Implications for Consumer Reporting

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Lise Rybowski

From the Agency for Healthcare Research and Quality, welcome to a podcast from TalkingQuality, a Web site about communicating comparative information on health care quality to consumers. I'm Lise Rybowski from the Severyn Group and I manage the TalkingQuality project.

I'm here today with Ted von Glahn, Senior Director of Performance Information and Consumer Engagement at the Pacific Business Group on Health. For about 10 years now, Ted and his colleagues have worked with the State of California to score and report the quality of health plans and medical groups in the state. The Office of the Patient Advocate, or OPA, is the state agency that publishes these quality performance results, which you can see at www.o-p-a-c-a.gov [www.opa.ca.gov].

A few years ago, the OPA decided to add CAHPS survey results for preferred provider organizations, or PPOs, to its public report on enrollees' experiences with health plans. What they found were significant differences between the PPOs and the HMOs in the overall rating of care measure. I asked Ted to join us today to tell us more about this finding and the implications for reporting survey results across different types of plans.

Ted, thanks for joining me today. Let's start with some background. What did you find when you tried to report similar measures for the HMOs and PPOs?

Ted von Glahn

We had a conversation with several of the major health plans in California who have large blocks of PPO business here in the state. And prior to getting underway with our own work with the State of California, Blue Shield of California and Anthem Blue Cross had approached us with concerns as we were moving into PPO public reporting here -- concerns about the results of their CAHPS member survey in the PPO setting. Interestingly, they had conducted CAHPS surveys of their PPO members concurrently and independently, and arrived at very similar results, which were pretty disturbing to both of the plans because of the variation in scores across their PPO membership.

And again, very similar results for both of the plans which showed, in that mix of members who responded to the CAHPS survey for their PPO block of business, at one end of the spectrum those members who were drawn from their large group segment scored quite favorably. And versus those who were drawn from the individual products and small group products in the PPO block of business scored quite unfavorably. And the gap was about 20 points between those on the high end, those in the large group market, and those in the small group individual market. Of course, a 20% swing in a CAHPS score for the global rating of plan, most importantly, is a huge difference.

So we began a conversation with that as the backdrop, which is to say, these results are pointing to some anomaly. Beware if we turn to the marketplace with public reporting through the State of California where we're presenting the historic HMO results for members' experience with the plan and then of course, side-by-side, the PPO results for the major PPOs here in the state. So that's what prompted a deeper dive to assess what was behind those differences in the scores.

Lise Rybowski

So what do you think was driving those results?

Ted von Glahn

Our hypothesis was that there was a greater cost burden among a segment of PPO enrollees that was influencing their experiences with the PPO, because we had this very blunt piece of information that those in the small group market and in the individual market were rating their health plan much less favorably, although rating their doctor experiences equivalent to members drawn out of the large group market. So to be clear that this wasn't a uniformly negative voice coming from these members, but rather it was particular to certain aspects of the plan experience, including the overall rating of plan and items in the CAHPS survey that we think of as sort of the health plan-centric items: the customer service, the claims experience, and so forth. That's where we saw these swings in scores. So our hypothesis based on the information supplied by the two health plans was that something about their cost burden – their cost at time of service whether it was deductibles, co-insurance, co-pays, and so forth – was influencing their experience with the plan overall.

So to examine that hypothesis, we added several questions, supplemental questions, to the CAHPS survey and the 2009 reporting year survey, and those questions were reaching to the issue of “did you as a member of the plan ever delay or not fill a prescription because of cost during the past year?” And similarly, the second question was “did you delay or not seek medical care because of cost in this past period?” So those two items were added to the CAHPS survey for four of the health plans in California and actually eight products – so both to the HMO and PPO samples that were reporting on their experiences for those four plans and their respective products, the HMO and PPO products offered by the plans.

Lise Rybowski

So what kinds of analyses did you do with those new questions then?

Ted von Glahn

Probably the most important finding was the folks who reported skipping or deferring care reported markedly less favorable results about their experiences with the plan. As an example, [for] those who reported skipping or deferring medical care versus those who did not, we saw scores that were 21 points lower on the global rating of plan for that subset of members. And similarly for those who reported skipping a prescription, that point swing was 15 points lower. So those who were deferring care for prescriptions were rating the plan overall 15 points lower than those who reported not deferring or skipping care.

So again, very large swings in the overall results at that global rating of plan level. I'd say notably these members were not universally negative, which is to say if you looked at their ratings across what we think of as more of the delivery system and doctor-centric questions in CAHPS, like the communication questions, the preventive care questions, and so forth, there was a slight fall off. So again, [for] those who are reporting cost burden, perhaps their ratings were one, three, four points lower than those who did not for those more doctor and delivery system-centric items, but not nearly the 20-point swing we saw on the global rating of plan.

So a pretty strong result and of course difference between those folks who we think of as cost sensitive, clearly their care was being influenced by their out-of-pocket costs.

Lise Rybowski

That's pretty consistent with what your hypothesis was. Were you surprised by anything that the data revealed?

Ted von Glahn

Not surprised. I would say it, as you say, it was consistent with what we had seen from the two plans here in California. Also at an earlier point, the Aligning Forces for Quality folks had done some work across the various sites in the United States that participate in that program and had used similar questions in their work. And again, order of magnitude, very similar results around a subset of folks who were reporting a cost burden and deferring care because of it. We took it in a somewhat different direction by again sort of zeroing in on the impact specifically on the CAHPS questions and this comparison across PPOs and across PPOs and HMOs.

But I think again, quite consistent with work that's been done elsewhere. I think the, a little bit of a light bulb moment for us was the realization that, in this era of larger increases in cost sharing, there are some downstream effects that we haven't really thought through very well as an industry. These downstream effects are appearing here in the CAHPS results. What we're seeing in part is that, of course, we're encouraging all of us as consumers to be better consumers of health care. We're getting incentives and motivation to shop, but I think we need to pause and recognize that we're asking consumers to shop in a store that doesn't have any prices on the shelves. And they certainly don't have any cost per ounce or per quantity information on those shelves. So many consumers are sort of left standing in the aisle chatting it up with their neighbors to help them shop. What we're seeing clearer, although I think more work is certainly needed is that, this isn't just about "oh I have to pay more out-of-pocket when I get care, therefore I'm unhappy."

And I think the careful assessment of our findings is, "I am unhappy, but part of the reason I'm unhappy is I need more services from the health plan because I do have greater cost sharing obligations. My benefit design is more complicated." Whether that's, "I have tiering of my drug costs for generics and brand and formulas and so forth," or "I have differential cost sharing for certain types of services," or "I have a personal account design." These are fairly complicated instruments and to help me as a consumer navigate them, the health plan has to step up and has to help me both understand how to best use my benefit designs and how to shop, how to buy carefully and thoughtfully.

And part of what we're finding in these results is the plans are coming up short in that regard. So when you look at these ratings, part of what you see is the more members use the plan, the less favorably they rate the plan. If I'm that person in the CAHPS survey that passes through the question, "did you have a claims experience?" "Did you have a customer service experience?" Boom, I'm going to rate the plan lower.

I had that claims experience, I had that customer service experience, I had that experience of looking for cost information, and on average, I had a less favorable assessment of the plan overall. So it's pointing to members turning to the plan for support for services in this period of increased cost sharing and again, in certain regards, the plans haven't stepped up to the plate well enough for a number of their members.

Lise Rybowski

So what are the implications of your findings for reporting the results, which was the original reason you went down this path? Can you still do it?

Ted von Glahn

Yes we can report them, but it prompted us to turn to creating two new indicators of performance using the CAHPS questions. And this was driven in part by our earlier discussion that the global rating of plan can mislead consumers so we were quite wary of using that and certainly not using it alone. I think that's an important consideration for any of us working in this area is, I think we would fail consumers and fail the industry if we used the global rating of plan sort of as a solitary or paramount indicator of performance given these findings.

So most importantly was this notion of let's help people understand two key aspects of the health plan, that members experience, one is around plan service, and one is around getting care and access to care and treatment. So we created a summary indicator of plan service and that was a roll-up of three of the CAHPS composites: the paying claims, the customer service, and the information on cost. Those three composites were aggregated into a summary indicator of plan service.

And then similarly, we created a second access indicator that we labeled "getting care easily" and that was a roll-up of the two access composites in CAHPS: the appointment scheduling within the doctor care system world, and then the getting needed care, access to test and treatment, and so forth. So those two composites were rolled up into this second access indicator.

Lise Rybowski

So what do you think are the most important implications of this work for others who are reporting on health plan performance?

Ted von Glahn

I think most importantly is, of course, beware of the global plan rating and that it's certainly reasonable to use it, but as I was saying, don't use it in isolation. We better understand now that it's masking differences in members' experiences. That it's important to understand that people who are having these experiences of paying claims and searching for costs information and so forth are having an experience that's quite distinct and again less favorable overall and certainly much less favorable than the experiences they report about their doctor and their care.

More than ever, it's important to zero in on the plan service topic in particular. I would also say that this is an easy one in the sense that this is a topic that matters to people when you look at what the strongest predictors of members' overall rating of plan; the strongest predictors are in fact those elements that comprise plan service. So there's a pretty compelling rationale that you want to shine a light on plan service given its influence on the global rating of plan. But also, because it's more discreet, that you're picking up a signal about people's experiences when they need help, when they need help with a particular aspect of the plan. So I would highlight that.

I think the other thing that, the nuance in this is this issue of both the influence of the financial burden just generally and the influence of these less favorable experiences when I have an exchange with my health plan about claims or getting cost information. So to know that both of those things are underneath the hood, are driving some of these results, at the end of the day, we should consider if we can provide comparisons to consumers that are more apples-to-apples around the type of plan that they are considering.

And I think an easy way to provide an example is if we step into the health reform world and the configuration of plans that's been proposed for the health exchanges, where we're talking about plans that are tiered as bronze plans, or platinum plans, or gold plans -- plans that are categorized by the benefit design and the overall out-of-pocket requirements. That's a nice structure to consider reporting these results because you've got some of that apples-to-apples. So if I'm looking at all of the bronze plans and understanding that all of the members that are reporting experiences, at least they're standing in the same shoes I'm standing in perhaps, which is cost sharing at level X. This would be an opportunity, as we think about the health exchanges, to perhaps organize the CAHPS information a bit more by type of plan and by people, again, that are having experiences that I could have given similar out-of-pocket costs.

Lise Rybowski

That's interesting, I think definitely worth consideration. My last question for you is about the employers and the payers who are designing benefits. What do you think they can learn from your research?

Ted von Glahn

I think particularly important that employers and other sponsors of health benefit programs understand this downstream effect -- that the increased cost sharing is pointing to a more complicated landscape for the consumer and the infrastructure hasn't caught up to that yet. That the cost information isn't available, that customer service isn't quite up to snuff in a world of very complicated benefit designs. And the explanation of benefit that the member receives for that claim and so forth. It's just a lot more work to ascertain either for purposes of shopping, to get a price and to understand the apples-to-apples on that price, or on the back end, to pay my share of the cost and to understand what my share of the cost is, is more difficult in this era. So I think employers need to better understand that and better educate themselves and the workplace about those issues.

And I would say secondly, to alert their employees and family members to ways to save money and of course that there are opportunities in the benefit design and the ones that are -- would be called out is everything from that preventive care visit, which is typically now fully covered for many people. On the other end of the spectrum, to alert people to where cost sharing has a fairly big impact in opening our wallets for a lot of people. And examples of that could be the use of x-ray and imaging services; it's quite easy to pay a \$1,000 out of your pocket for an MRI if you're in a world of a \$1,000 or higher deductible, which is quite common today. So for people to be alert to the alternatives to incurring those sizeable out-of-pocket costs is another role that I think employers can play.

And of course as a prod and to control, I think that better consumer shopping tools are needed and those tools need to be personalized to that individual: to the fee schedules in that area, to their benefit designs and their actual out-of-pocket costs, if they choose option A versus option B. I think those are all roles that the employer and benefits sponsors can play.

Lise Rybowski

Well thanks so much Ted, this has been really interesting and I very much appreciate your sharing these findings with others who report on patient experience with health plans. You can see how the Office of the Patient Advocate presents scores for HMOs and PPOs in California at www.o-p-a-c-a.gov [www.opa.ca.gov].

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