

Consumer Choice of Plan Research Deliverables for the Exchanges

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Project Purpose

- Many consumers are likely to make the “wrong” plan choice when selecting a health plan on an Exchange.
- Our research is designed to help Exchanges answer the question:

How can we help consumers choose a quality plan at an affordable price when they make their selections on the exchange?



Project Deliverables

Deliverables

Consumer Choice of Plan Research Findings

decision support research findings to guide planning for Exchange service

IT Vendor Procurement Business Requirements

business rules to embed in plan choice decision-support software

Health Plan Information Requirements

data elements required for plan choice

Research: Initial Phase 1 Questions

- Are consumers more likely to select the least costly plan if they are presented with four vs. eight options?
- Does adding plan quality information to the cost comparison improve likelihood of choosing the right plan?
- Does presenting a summarized total cost figure vs. cost components (premium, deductible, copays) improve the likelihood of choosing the best plan?

Methods Highlights

- First 4 experiments involved more than 1,000 participants
- Participants were provided a simplified plan choice scenario with one dominant option
- Participants were recruited through online marketing services

Research: Initial Phase 1 Findings

Health plan choices are very difficult. Participants do only slightly better than chance at selecting the “best” plan, even in simplified environments.

- ✓ Even when comparing only four plan options, choosing the right plan proved difficult.
- ✓ A cost calculator that summarizes total plan cost helped.
- ✓ The addition of quality ratings did not diminish the odds of choosing the most affordable plan.
- ✓ Participants most valued a cost calculator; help from family, friends, experts also valued.

“Please indicate which resources you used or would like to have had access to:”

Resource	Calculator	Peer Chat	Expert Chat	Talk to Family	Talk to friend
Proportion Agreeing	63%	5%	32%	33%	21%

Research: Remaining Phase 1 Questions

- Are plan choice decisions particularly hard because they concern getting medical care?
- If quality information is presented as a central element of plan choice, does it impact choice performance?
- If the subject is presented with a higher likelihood of future illness, does that impact choice performance?
- Does setting default plan options improve choice?

Business Rule: Plan Cost

Summarize Costs: Apply math logic to sum the premium and the estimated cost at time of care and display a total cost amount.

Cost Calculator: Use a calculator to provide user with annual cost at time of care estimates given the plan's covered benefits and the user's expected medical services use.

Plan	<u>Your Employer's Contribution (Per Month)</u>	<u>Your Actual Premium Contribution (Per Month)</u>	<u>Your Actual Premium Contribution (Yearly)</u>	<u>Your Estimated Cost at Time of Service (Yearly)</u>	<u>Your Estimated Total Cost (Yearly)</u>
Plan A	\$100.00	\$363.12	\$4,357.44	\$236.00	\$4,593.44
Plan B	\$100.00	\$435.73	\$5,228.76	\$25.00	\$5,253.76
Plan C	\$100.00	\$459.11	\$5,509.32	\$25.00	\$5,534.32

Business Rule Rationale:

based on research evidence per initial experiments

- The odds are worse than random chance that people will choose a health plan that is less expensive if the user has to determine their expected costs by converting benefits coverage (e.g., deductible and copay amounts) into an expected cost for that plan and combine that value with the premium amount.
- Calculators significantly improve choice.
- People want calculators to assist them in their decision-making.

Business Rule:

Hierarchy of Plan Choice Dimensions

Dimensions Hierarchy: Construct a hierarchy of plan choice dimensions comprised of several layers of information that are displayed in plan comparisons. The user navigates through these information layers. The lower tier(s) of hierarchy can be single plan information details.

Top Hierarchy of Plan Choice Dimensions: The top tier of hierarchy should be limited to 6 or fewer choice dimensions. The default top dimensions should include plan quality and cost.

Plan	Costs			Doctors	Quality Ratings	Features	Services
	Total Cost (Yearly)	Your Premium Cost (Yearly)	Cost at Time of Service (Yearly)				
Plan A	Good Fit \$1,186.96	\$876.96	\$310.00	None of my doctors	****	Select PCP	Good Fit

Business Rule Rationale:

based on research evidence per initial experiments

- When cost and quality are concurrently presented the quality measures do not diminish the odds of people making the ‘right’ plan choice and they may improve the odds of a right choice.
- The concurrent availability of quality metrics and summed plan costs per a “cost calculator” seem to act jointly to improve the odds of making the ‘right’ plan choice.

Health Plan Information Requirements



Eligibility

User and household eligibility requirements for exchange programs.



Doctor Choice

Searchable physician, hospital and pharmacy directories by plan. Plan rules to see a doctor. Doctor accessibility.



Premium Cost

Total premium; premium tax credit or other subsidies, and net premium to consumer



Quality

Member ratings of plan; provider network clinical quality results; systems to ensure patient safety, get health promotion services & engage in self-care.



Plan Features and Rules

Wellness resources, health coach, or other services for your health problem(s). Services to save money. Rules about designated providers and programs for select services.



Covered Services

User payments when getting care – deductibles, coinsurance or other fees for office visits, hospital stays, medications and other services.



Cost When Getting Care

User's expected medical services use for upcoming year yields an annual out-of-pocket cost estimate.

Deliverable

Data elements required from Exchange health plans for consumer plan choice

Health Plan Data Elements Deliverable

Doctor Choice Domain

Category	Element	Description	Data Characteristic	Data Source
Access to Provider Rules (at level of Issuer, Line of Business, Level of Coverage, Qualified Health Plan)				
	Specialist Referral	Is referral needed for the individual to access a specialist/designated services?	Y/N	Issuer
	Specialist Referral Types	Designate specialties that require a referral	Specialty Codes	Issuer
	Specialty Services Referral Types	Designate specialty services that require a referral	Service Codes (e.g., behavioral health)	Issuer
	Primary Care Physician (PCP) Designation	Must enrollee choose/enroll with a primary care provider?	Y/N	Issuer
	Service Area	Are higher coverage levels specific to a designated geographic area?	Y/N	Issuer
	Zip Codes	Provide geographic parameters for service area	Zip Codes	Issuer
	Provider Network	Does plan use a network of providers?	Y/N	Issuer
	Out of network authorization	Is an authorization required to use an out-of-network provider?	Y/N	Issuer
	Out of network coverage	Is out-of-network coverage available at lower coverage level?	Y/N	Issuer

Research Project: Status and Next Steps

1. Phase 1 consumer research is underway – grant funding startup
 - Robert Wood Johnson Foundation
 - Sloan Foundation
2. Phase I results to be delivered Jan -Mar. 2012
 - Secondary goal of research is to support curriculum of navigator programs
3. Stakeholder Engagement:
 - Advisory Board comprised of experts in consumer decision-making, health insurance, and exchange technical assistance, in addition to representatives of state exchanges
 - Coordinating with UX2014 project
4. For Phase II (Feb. – Sep. 2012) seek Foundation and State Exchanges' financial support