Choosing A Health Plan: Do Large Employers Use The Data?

Purchasers of health care coverage for more than 1.8 million consumers suggest that “information overload” and other factors affect their use of performance data.

by Judith H. Hibbard, Jacquelyn J. Jewett, Mark W. Legnini, and Martin Tusler

**Abstract:** Significant private and public resources go into the production of various types of performance measures: from patient satisfaction with nonclinical service to clinical outcomes. While recent investigations have focused on the effect of clinical outcomes information on clinical practice, almost no work examines its effect on purchasers’ decisions. This study examines how large employers use performance information, including clinical outcomes, in purchasing decisions. Representatives of thirty-three large employers that purchase for 1.8 million covered lives were interviewed in early 1997. Findings suggest that purchasers are not always aware of clinical outcomes data and that measures do not meet their decision-making needs. Further, the variety and amount of performance information to process for purchasing decisions is a barrier to effective decision making. Recommendations for supporting purchasers’ use of performance information, especially clinical outcomes data, are included.

Large employers purchasing health benefits for their workforce are in a strong position to influence the health care marketplace. Many have used their purchasing power to obtain discounts and cost savings from health plans and thus have increased price competition among plans and providers. By making quality of care a purchasing criterion and requiring evidence of quality, large purchasers also can use their power to create competition on the basis of quality and outcomes.

Purchasers’ decisions have important implications for consumers. They determine their employees’ health care options and thus may influence the quality of care that workers and their families receive. Further, employers can play an important role in educating their employees about quality issues and providing comparative information on health plan performance.

Performance information is an umbrella term that encompasses both service quality (for example, customer service and claims processing accuracy) and clinical quality (including processes and outcomes of care). Outcomes of

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care are considered the most valid measures of clinical quality. That is, multiple measures of clinical quality exist, but there is an implicit hierarchy of indicator types, with outcomes of care at the top.¹

Since they first appeared in the mid-1980s, hospital outcomes reports have remained the only publicly available measures of clinical outcomes. These “report cards” were expected to provide the acid test of quality—not patient satisfaction or process measures of care, but true measures of clinical quality such as mortality after surgery or complications of hospital treatment. Since the mid-1980s, however, other performance measures, such as the Health Plan Employer Data and Information Set (HEDIS), have been developed. Although HEDIS measures are more widely used, most experts believe that they are weaker measures of quality of care than are risk-adjusted outcomes data.

This analysis looks at how large purchasers see this issue, how they perceive the differences among various performance measures, and what types of performance information they use. The purchasers represent four regions of the country where hospital outcomes measures are available: California, New York State, Pennsylvania, and metropolitan Cleveland, Ohio. This study examines the use of clinical outcomes data from hospitals, HEDIS health plan reports, and consumer satisfaction data. The principal research questions were the following: (1) Are purchasers aware that performance data are available? (2) What performance information is used in purchasing decisions? (3) How is performance information used in decisions? (4) How is the information understood? (5) Do purchasers disseminate the performance information to employees?

METHODS

The sampling frame was defined by size of employer and access to hospital outcomes data. In Pennsylvania and Cleveland, selections were made from the strata of large employers that also appeared on mailing lists for receiving hospital outcomes data from data-producing organizations. In California and New York a viable mailing list did not exist, so selection was based solely on employer size.

We contacted and interviewed purchasers between February and April 1997. Cold calls were made to 107 potential interviewees; after repeated attempts, about half of the purchasers were reached. Of those reached, sixteen refused to participate, which yielded a 67 percent participation rate. The individual respondents were screened to ensure that they had a decision-making role in hospital and plan selection in their organization. Eight to nine in-depth interviews were conducted in each of the four regions. The thirty-three interviews were recorded and transcribed. The average interview lasted thirty minutes and included both closed and open-ended questions. The open-ended questions were coded and analyzed. Specific codes were developed to categorize responses to specific open-ended questions, and global codes were developed for issues that might surface in any part of the interviews, such as the extent to which the respondents used consultants. Interrater reliability on code categories showed 98 percent agreement.

INTERVIEW RESULTS

The thirty-three purchaser representatives interviewed were together responsible for more than 1.8 million covered lives. In California our average employer was purchasing care for 96,306 covered lives; in New York, 102,971; in Cleveland, 38,071; and in Pennsylvania, 13,080. The distribution of employees in different plan types varied by region. The California purchasers reported that 49 percent of their employees were in health maintenance organizations (HMOs). These proportions were 22 percent in Cleveland, 29 percent in Pennsylvania, and 29 percent in New York. New York purchasers reported the greatest number of employees in indemnity plans (22 percent) and California the lowest number (7 percent). In Pennsylvania, 20 percent, and in Cleveland, 13 percent of the purchasers’ employees were in indemnity plans.
REPORTED AVAILABILITY OF DATA.
The reported availability of HEDIS and patient satisfaction data varied across the regions. This variation may reflect either differences in awareness or actual differences in the availability of data. Reported availability of HEDIS data ranged from 63 to 88 percent across the regions (Exhibit 1). An average of 78 percent of the purchasers reported that HEDIS data were available to them. An average of 75 percent of purchasers reported that consumer satisfaction data were available.

Hospital outcomes data are available to purchasers in all four regions, but this was not always the perception among the purchasers. The percentage of purchasers who were aware of the availability of hospital outcomes data ranged from 25 to 71 percent across the regions. Awareness was highest in Cleveland and Pennsylvania, perhaps because the data-producing organizations in these two regions define part of their mission as providing information to purchasers. They disseminate quality reports directly to purchasers and have purchaser members on their boards of directors. The data-producing organizations in the other two regions do not have a special focus on purchasers.

TYPES OF DATA USED. Purchasers reported using three types of performance measures fairly consistently: HEDIS, consumer satisfaction data, and National Committee for Quality Assurance (NCQA) accreditation. The use of HEDIS data was similar across the four regions. Among those who reported that HEDIS data were available to them, 54 percent reported using HEDIS for choosing a plan (Exhibit 2). When including all purchasers in the analysis (regardless of reported HEDIS availability), only 45 percent reported using the data.

The purchasers with the most employees were more likely to use HEDIS. The HEDIS users had an average of 38,738 employees; nonusers had an average of 29,508 employees. However, having employees in HMOs did not appear to be related to using HEDIS. Overall, the HEDIS users had 34 percent of their employees enrolled in HMOs, whereas nonusers had 35 percent enrolled in HMOs.

Eighty-five percent of those using HEDIS data also reported using consumer satisfaction data for choosing plans. Among those who reported that consumer satisfaction data were available to them, 59 percent said that they used the data (with a range of 43–83 percent across the regions) (Exhibit 2). When all purchasers were included in the analysis (regardless of reported availability of consumer satisfaction data), 53 percent reported using

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**EXHIBIT 1**

Purchasers Reporting Availability Of Selected Quality Indicators, By Region, 1997

<table>
<thead>
<tr>
<th>Percent of surveyed purchasers</th>
<th>HEDIS</th>
<th>Consumer satisfaction</th>
<th>Hospital outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>60</td>
<td>40</td>
<td>20</td>
</tr>
<tr>
<td>80</td>
<td>75</td>
<td>67</td>
<td>50</td>
</tr>
<tr>
<td>60</td>
<td>88</td>
<td>86</td>
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<td>40</td>
<td>86</td>
<td>71</td>
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<td>20</td>
<td>89</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>0</td>
<td>78</td>
<td>78</td>
<td>78</td>
</tr>
</tbody>
</table>

SOURCE: Authors’ analysis, 1997.
NOTE: HEDIS is Health Plan Employer Data and Information Set.
the data. The use of NCQA accreditation information averaged 55 percent and ranged from 43 to 67 percent across the regions (not shown). Among those using NCQA accreditation information, 54 percent also reported using HEDIS. These findings are consistent with other reports of large employers’ use of performance information.2

The purchasers used hospital outcomes data much less consistently. Among those who reported that such data were available to them, 25 percent said that they used the data. However, across the regions, use ranged from 0 to 80 percent (Exhibit 2). When all purchasers were included in the analysis (regardless of reported availability of hospital outcomes data), only 16 percent reported using the data. Cleveland is the only region where much direct hospital contracting occurs (75 percent of those who used hospital contracting were from Cleveland). Cleveland is unique in that its hospital outcomes data are produced by Cleveland Health Quality Choice, a private membership organization (public agencies produce the data in the other three sites). The organization is financially supported by the members, and they are the potential users of the data. To earn access to the data, members must attend educational orientation and pay a fee. The level of commitment required of the potential users probably contributes to their greater use of the available information.

### ABOUT DATA CHOICES

Purchasers cited a number of reasons for not using hospital outcomes or HEDIS data. Some of their reasons provide valuable insights into how to make quality information more accessible and useful to this population. For example, regarding hospital outcomes data, purchasers said that (1) they have concerns about hospital outcomes measurement methodology and whether the data are timely and valid; (2) some expect the managed care plans to monitor hospital quality; and (3) the information is not packaged for their needs (for example, they would prefer it to be organized by plan).

Similarly, regarding HEDIS data, purchasers noted that (1) HEDIS is seen as unrelated to their decision criteria (such as financial stability of the plan, cost, and geographic access); (2) purchasers sometimes have no choice of plans; (3) HEDIS is viewed as not providing the information they need on outcomes, cost-effectiveness, and service quality; and (4) some purchasers rely on NCQA accreditation, con-
sultants, or HMOs for quality monitoring.

T r u s t i n g h e a l t h p l a n s t o m o n i t o r t h e q u a l-

ty of hospitals is troublesome. If employer

purchasers are holding health plans account-
able on costs and at the same time trusting the
plans to monitor and select on hospital quality,
health plans might not have sufficient incentive
to selectively contract with high-quality
hospitals.

M a n y p u r c h a s e r s i n d i c a t e d t h a t q u a l-

ity and outcomes were important to them, but
when asked what performance information is
most influential in their decisions, they listed
consumer satisfaction data, followed by
NCQA accreditation. NCQA accreditation is
not an especially strong discriminator for
choosing among plans based on clinical
quality. S o w h y w o u l d l a r g e p u r c h a-

s e r s r e l y o n t h e s e m e a s u r e s w h e n m o r e
clinically oriented measures are available? This enigma becomes
clearer as we examine the decision process.

■ D E C I S I O N S , D E C I S I O N S . D e c i s i o n
m a k i n g r e q u i r e s t h e a b i l i t y t o i n t e r p r e t a n d
i n t e g r a t e i n f o r m a t i o n . ³ P e o p l e c a n e f f i c i e n t l y
p r o c e s s a n d u s e o n l y f i v e o r s i x v a r i a b l e s o r
pieces of data in each decision. W i t h m o r e
information, a person’s ability to use that in-
f o r m a t i o n d e c l i n e s . T h e v o l u m e o f i n f o r m a-
tion available for comparing plan performance
and characteristics is considerable. Purchas-
ers d e a l w i t h a s m a n y a s t h r e e d i f f e r e n t c a-
g e g o r i e s o f p e r f o r m a n c e i n d i c a t o r s ( f o r e x a m p l e,
service quality, consumer satisfaction, and
HEDIS), each with multiple measures. T h e
purchasers in our survey reported purchasing
h e a l t h c a r e s e r v i c e s i n a n a v e r a g e o f t w e n-
one states. E a c h s t a t e m a y h a v e m u l t i p l e m a-
kets. W i t h i n e a c h m a r k e t , p u r c h a s e r s c o n-
sider three to four health plans. T h e m o r e
states they purchase in and the more plans
they consider in each market, the less likely
they are to use HEDIS or consumer satisfac-
tion data when making their decision (Ex-
hibit 3). Purchasers in our survey who did not
use either consumer satisfaction or HEDIS
data purchased services in more than twice as
many states as did those who used the data.
T h e i n f o r m a t i o n - p r o c e s s i n g l o a d c r e a t e d b y
more options appears to deter purchasers
from using performance data.

N C Q A a c c r e d i t a t i o n i s l i k e l y a n a t t r a c t i v e
s e l e c t i o n c r i t e r i o n b e c a u s e i t i n t e g r a t e s a n d
summarizes several characteristics in one
e a s i l y t o u n d e r s t a n d m e a s u r e . I t a l s o r e d u c e s
the information-processing burden by allow-
ing decisionmakers to rely on expert assess-
ment rather than their own interpretation of
the data.

■ D E C I S I O N - M A K I N G S T R A T E G I E S . L a r g e
employers generally are interested in getting a

### EXHIBIT 3
Data Considered By Purchasers When Selecting Plans

<table>
<thead>
<tr>
<th>Data used</th>
<th>Average number of states where plans are purchased</th>
<th>Average number of plans considered per market</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uses HEDIS</td>
<td>16.3</td>
<td>3.0</td>
</tr>
<tr>
<td>Does not use HEDIS</td>
<td>26.3</td>
<td>3.7</td>
</tr>
<tr>
<td>Uses consumer satisfaction data</td>
<td>17.2</td>
<td>2.8</td>
</tr>
<tr>
<td>Does not use consumer satisfaction data</td>
<td>34.1</td>
<td>3.8</td>
</tr>
<tr>
<td>Uses both HEDIS and consumer satisfaction data</td>
<td>13.9</td>
<td>2.8</td>
</tr>
<tr>
<td>Uses neither HEDIS nor consumer satisfaction data</td>
<td>28.5</td>
<td>3.7</td>
</tr>
</tbody>
</table>

**SOURCE:** Authors’ analysis, 1997.

**NOTES:** Hospital outcomes data are not included in the analysis because almost all users of these data are from Cleveland.

HEDIS is Health Plan Employer Data and Information Set.
good price for the services they buy, keeping their employees happy, and purchasing from high-quality health plans and hospitals. Not only are purchasers using multiple factors in their decisions, they also are trying to achieve multiple goals. When multiple comparisons are made using different types of variables, the information becomes more difficult to evaluate.⁴ Consider a choice between a plan that performs well on consumer satisfaction and has a large and diverse physician panel but has less geographic access and another plan that has only average consumer satisfaction and is more costly. How should a purchaser weigh each of these factors and bring them together into a choice? Research on cognitive strategies used in decision making suggests that when faced with complex decisions, people may try to simplify their choices by comparing alternatives based on a single important dimension (while leaving out other important dimensions) or by defining the problem so that one alternative seems to dominate the others.⁵

Half of the purchasers in our survey thought that it was difficult or very difficult to bring all of the variables together into a decision. Twelve percent reported that they made their choices on the basis of a single dimension such as cost or geographic access. This is a reasonable response to a decision that involves multiple markets, but it clearly leaves out important considerations.

Integrating conflicting dimensions of choice is an additional challenge. When faced with trade-offs, people tend to take shortcuts that may undermine their own interests.⁶ Purchasers in our survey were asked how they made trade-offs between cost and performance. Some said that they avoided making trade-offs altogether—for example, by offering all plans in a market or by putting the onus on employees: “We will sign up higher-quality, more expensive plans if the employees are willing to pay for them out of pocket.” Seventy percent of the purchasers were trying to find a balance between cost and quality, looking for cost-effective services. About 10 percent first chose a price range and then compared quality within that stratum, thereby letting cost dominate while still considering quality. The majority of purchasers said that they used their own subjective judgment in weighting factors and bringing them together into a decision. Only about 20 percent of the purchasers were using some kind of system for making trade-offs and identifying high-performing, cost-effective plans. Their systems ranged from a simple four-cell matrix or grid to an elaborate weighted formula. Those with a weighting system were able to be explicit about how they made their trade-offs.

When faced with complex information and competing objectives, people will give more weight to measures that are more precise and concrete and less weight to measures that are more difficult to evaluate.⁷ This suggests that when purchasers must trade off cost and quality, cost measures (which are precise, are direct, and have understandable consequences) may outweigh quality measures (which tend to be vague and are often proxy measures and less comprehensible) in the decision-making process, particularly if that process is subjective. Thus, even those purchasers who use quality information might not be placing the appropriate emphasis on it or using it in systematic and consistent ways.

It is not surprising, given the complexity of the task, that some purchasers either do not make choices at all or do not make choices themselves. Twelve percent of the purchasers in our survey said that they relied almost entirely on consultants to recommend plans. Forty-eight percent volunteered that they used consultants for obtaining or recommending data. However, only a subset relied on consultants to recommend plans.
A second group, representing 21 percent of the purchasers, said that they were not selecting plans at all but were maintaining long-term relationships with existing plans. These purchasers had not selected a new plan in three to nine years. They were not engaged in selective purchasing or any significant performance setting with their existing plans. Although 52 percent of the purchasers were involved in both selective plan purchasing and performance setting, almost all of the 78 percent who were setting performance standards were using service quality standards only.

**EMPLOYERS’ AND EMPLOYEES’ INTERESTS.** Purchasers use the terms *quality* and *outcomes* in various ways. About 12 percent of the purchasers used outcomes to refer to service quality measures, such as speed of claims processing and time it takes to answer the phone. Twenty-one percent either interpreted quality indicators as telling them about cost or equated high cost with poor quality. (“If the price is high, this is an indicator that something is wrong … [S]omething is not right about the way they are managing their care.”) This interpretation is likely to be at odds with how consumers would interpret high costs and quality. It highlights the potential incongruence between employees’ interests and values and employers’ interests and values with regard to health plan choice.

Employers can play an important role in educating employees about quality of care and providing employees with comparative quality information. Thirty-one percent of the employers in our survey indicated that they give performance information to their employees. Another 15 percent said that they were planning to do so in the future. However, among those who were providing this type of information to employees, some were skeptical about how often the information was used and how well it was understood. More than half of those providing data did not think that their employees used the information or thought that only some of them used it.

**DISCUSSION**

The methods used in this study were designed to gain insights into how purchasers make decisions and use information. Larger sample sizes would be needed to estimate the prevalence of purchasers’ use of clinical quality data. However, because of the large number of employees and their families (1.8 million) affected by these purchasers’ decisions, our findings are socially significant.

The use of clinical quality information among the purchasers observed in our study is relatively low, and not all of the purchasers were aware that performance data are available. While the degree to which HEDIS data and consumer satisfaction data are actually available to individual purchasers is not known, hospital outcomes data are available to all of the purchasers in this study. Purchasers’ awareness of the availability of these outcomes data appears to be related to the strategies used by the data-producing organizations. Awareness is higher in those regions where purchasers are specifically targeted to receive quality report cards and where the information is packaged specifically for purchasers. Awareness of the data is a necessary first step.

Familiarity with clinical outcomes data may broaden purchasers’ concepts of quality and may eventually affect the criteria that these employers use when purchasing. For now, it appears that purchasers give less attention to clinical quality measures than they do to service quality measures. Service quality measures are perceived to be more desirable in that they are more timely, more accurately measured, more easily understood, and immediately relevant to employees.

Effectively incorporating quality information into purchasing decisions goes beyond awareness and use of the data. It involves having explicit decision criteria and being able to consistently integrate and properly weigh multiple factors. It involves having a strategy for deciding what will be compromised when goals conflict. Using this standard, at most 20 percent of the purchasers in this study would
qualify as effective users of quality information. Encouraging effective use of quality data goes beyond dissemination strategies to the development of decision-support strategies.

Our results identify other barriers to the use of quality information. Purchasers do not always understand the intent of the quality indicators and do not always interpret them correctly. Sometimes purchasers are wary of the validity or value of quality indicators. Some believe that quality monitoring can be entrusted to others, including HMOs, consultants, or accrediting organizations.

The findings also indicate the potential incongruence between the objectives and interests of employers and employees in defining quality and determining priorities in health plan choice. In a 1996 consumer survey, 58 percent of consumers reported that they were wary of employers as a source of information about health plans. Employers now use consumer satisfaction survey data and employee complaints as a way of gauging employees’ concerns and incorporating employees’ interests in health plan selection decisions. Perhaps employers need to go a step further and use explicit employee-generated criteria in the selection of health plans. That is, the criteria and the weighting of the criteria used in health plan selection could be partially derived from employees. Although employers tend to give more weight to employee convenience than they do to clinical quality, if given the opportunity, employees might place greater weight on clinical quality.

RECOMMENDATIONS
Clinical quality has been the most elusive facet of health plan and provider performance measurement. After nearly a decade of access to hospital outcomes information in selected markets, purchasers’ use of clinical quality information is still limited or inconsistent. How can we hasten the use of quality measures, and how can we help those who are using the data to make their efforts more effective? Our findings provide some guidance for enhancing purchasers’ use of clinical quality information.

■ TARGET PURCHASERS. Quality information should be packaged and disseminated in a way that meets purchasers’ needs. Report cards should not be generic. While the data remain the same, the packaging, presentation (for example, hospital data by plan), and support for using the data should be audience-specific. The more that purchasers value the data and understand what to look for when using quality information, the greater the effect will be on the health care market.

■ A SUMMARY MEASURE. The development of clinical measures that summarize information in one or two easily understood indicators of quality of care would make it easier for purchasers to incorporate quality information into decision making. However, the degree to which such measures would be viewed as trustworthy and valid by purchasers and clinicians would need to be empirically assessed.

■ DECISION AIDS. Purchasers need help integrating many different types of variables into their choices. Computer-aided decision tools that elicit preferences and values can assist purchasers in making decisions that reflect their goals. A good decision-support tool should reduce the information-processing burden by breaking down decisions into manageable steps and guiding decision making through preselected criteria. Such tools bring data together in a way that ensures that vital pieces of information are not lost and are properly weighted in decisions. The focus is on proceeding through a rational process that is based on the known principles of decision making. This may be especially important for employers that want to incorporate employees’ perspectives into the criteria used in plan selection.

■ COMMUNICATING WITH WORKERS. Communicating with consumers about quality of care is a new arena, and there is still much to learn. Early studies suggest that consumers need a better understanding of the current health care context to effectively understand quality information. Although consumers are familiar with comparing plans on cost and benefits, the idea that plans might vary on quality is new to many consumers.
There is a growing realization that effective communication about quality may require a larger consumer education effort than simply distributing quality reports during open enrollment.

Resources to help purchasers to design communication strategies are now available. For example, the Consumer Assessment of Health Plans Study (CAHPS) is assessing ways to effectively deliver quality information to different consumer populations. The Foundation for Accountability (FACCT) has ongoing projects to evaluate approaches to using quality-of-care information. FACCT can provide technical assistance to employers that need models for communicating about quality. Similarly, the Quality Measurement Advisory Service (QMAS) provides technical assistance to purchasers on the use of information about quality. In addition, purchasing coalitions are experienced at testing different approaches to reporting quality information to consumers and communicating about quality concepts.

Our findings indicate a need to support and encourage large purchasers in the use of quality information and point to some specific strategies for enhancing purchasers’ use of performance information. Because purchasers play a key role in maintaining quality in a competitive health care market, supporting their information and education needs should be high on the policy agenda.

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NOTES