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RAPPORTEUR NOTES

HSRMC 2020 Session 6: Health Insurance Attitudes Towards Cost of Care
8:30 am to 11: 30 am, Saturday, March 7, 2020
Chair Susan Paddock (NORC)
Discussant: ~~Sophia Chan (CMS)~~ Liz Hamel (KFF)
Rapporteur: Fran Chevarley (Independent Consultant); Matthew McIntyre (23andMe)

1.Kathleen Call (UMN): Health Literacy: How Best to Measure and Does it Matter to Health Care Access and Affordability (by Kathleen Thiede Call, Ann Conmy, Giovann Alarcón, Sarah Hagge, Alisha Baines Simon)
2.Ashley Kirzinger (KFF): Measurement Issues in Determining How Many Americans Struggle Paying Medical Bills (by Ashely Kirzinger, Ph.D. KFF; Eran Ben-Porath, Ph.D., SSRS; Liz Hamel, KFF)
3. Didem Bernard (AHRQ): Measures of Health Care Affordability: Financial Burden and Barriers to Care (by Didem Bernard and Thomas Selden)

RAPPORTEUR NOTES FROM THE PRESENTATIONS AS BACKGROUND
All three presentations compare different estimates for similar topics: Kathleen compares two different Health Insurance Literacy (HIL) measures; Ashley compares two measures for problems or being unable to pay medical bills (an NHIS vs KFF question); and Didem compares five measures of health care affordability using MEPS including the NHIS measure in Ashley's presentation.

Kathleen's two different sets of HIL questions ask the respondent to report for themselves. The "Likelihood" measure is based on the American Institutes for Research's (AIR's) Health Insurance Literacy Measure © (HILM) 21 self-report questions assessing self-confidence and behaviors associated with choosing and using health insurance (4 domains). The HIL "Likelihood" measure used 3 of the 4 questions in the "proactive choice" domain of the Health Insurance Literacy Measure © (HILM) questions. The "Likelihood" questions ask the respondent to report on how likely the person is to perform three health insurance tasks (the data has the response categories Very likely, Moderately likely, Somewhat likely, Not at all likely, Don't Know, Refused (Missing)). Those reporting Very likely (vs. Moderately likely, Somewhat likely, Not at all likely, Don't know) for all three tasks are defined to be high HIL on the Likelihood of performing insurance tasks. The "Confidence" measure is based on the Health Reform Monitoring Survey (Urban Institute, 2019) Quarter 1, 2016, using the 7 item healthcare navigation measure adapted to 4 items. The "Confidence" questions ask the respondent to report how confident the person can perform four insurance tasks (the data has the response categories Very confident, Somewhat confident, Not too confident, Not at all confident, Don't know, Refused (missing)). Those reporting Very confident (vs. Somewhat confident, Not too Confident, Not at all confident, Don't Know) for all four insurance tasks are defined as having high HIL on the confidence in performing insurance tasks. To compare the "Likelihood" and "Confidence" HIL measures their respective HIL questions were randomly assigned to respondents in the 2017 Minnesota Health Access Survey. The Minnesota Health Access Survey is a statewide general population telephone survey of health insurance coverage and access in Minnesota with data back to 2001 and conducted biannually since 2007. The analyses is based on self-reported person level data from a telephone survey. Kathleen found that these "Likelihood" and "Confidence" HIL measures were associated with access to care but the "Likelihood"

HIL were negatively associated with 5 of 6 of the affordability measures; The "Confidence" HIL measure was positively associated with two of the 6 affordability measures.

Ashley compares an NHIS and a KFF question on problems or being unable to pay medical bills. For both questions, the respondent reports whether they or anyone in their family have problems or being unable to pay medical bills. Reporting for themselves or anyone in their family in Ashley's questions differs from Kathleen's HIL questions in which the respondent reports for only themselves (self-report). The main wording differences for the NHIS and KFF questions are: the NHIS questions includes examples of the types of medical bills to include after the question, and the KFF question includes these examples as part of the original question; and the NHIS question uses the terms "in the family" and the KFF question uses the terms "in your household". Ashley noted that the 2015 KFF question estimates using the Kaiser Family Foundation/New York Times Survey for percent of persons ages 18-64 who report they or someone in their family (NHIS)/household (KFF) were higher than similar NHIS question estimates using the NHIS. In trying to explain these differences, Ashley noted the following survey differences: response rates differ (70% for NHIS and 10% for KFF); Mode differences (mainly interviewer administered in face-to-face interviews for NHIS (where the questions are read to the respondent) and mainly web-based for the KFF (where the respondent reads the questions on the internet)); Sampling; survey sponsors; and Context (the NHIS questions are toward the end after the health insurance questions and the KFF questions are after the attitudes over ACA questions which are associated with people's political parties.) To better understand the NHIS and KFF questions, an experiment was done by placing both the NHIS and KFF questions on the SSRS Omnibus February 2020 survey. The SSRS Omnibus survey is a telephone administered survey in which the questions are read to the telephone respondent. Their results showed smaller differences in the KFF and NHIS question unweighted estimates when they were both in the same survey.

Didem discusses five affordability measures using 2016-2017 (years combined) Medical Expenditure Panel Survey (MEPS) data from AHRQ. The sampling frame for MEPS consists of responding households from the NHIS. The five affordability measures are: High financial burden; Problems paying bills (similar to the NHIS question in Ashley's presentation); Barriers to care; No usual source of care; and Food insecurity. The person-level information for each of these measures for each family member is obtained by the interviewer reading questions from a CAPI instrument to the family respondent. In this presentation the definition of family is based on the MEPS health insurance eligibility unit which includes all members of the family who would typically be covered under a private insurance family plan. The first measure, High financial burden, estimates number of persons who live in families with high burden where families with high burden are those whose total family health spending (includes out-of-pocket expenditures on health insurance premiums and on health care services) is greater than or equal to 20% of family income. The second measure, Problems paying bills, estimates the number of persons who live in families with at least one person with problems paying medical bills. The third measure, Barriers to care, estimates the number of persons who live in families with at least one person who delayed or was unable to get necessary medical care, prescribed medications or dental care for one of the following reasons: Could not afford care; insurance would not approve, cover or pay; or doctor refused family insurance. The No usual source of care measure estimates the number of persons who live in families with at least one person who does not have a usual source of care for financial reasons, or who reports the hospital emergency room as their usual source of care. The fifth and last measure, Food insecurity, estimates the number of persons who live in families where at least one family member with a food sensitive medical condition often or sometimes (versus never) had any of three food problems in the last 30 days. The three food problems are: worried that the food would run out before they got more money to buy more; the food they bought didn't last and they didn't have money to get

more; and they couldn't afford to eat balanced meals. Results were provided for non-elderly and elderly adults by insurance status, by race/ethnicity, by poverty, and by presence of medical conditions.

RAPPORTEUR NOTES FROM THE DISCUSSANT AND FLOOR DISCUSSION

I. General comments to all three presenters:

General comments from Liz

The Discussant, Liz Hamel (KFF) noted three common themes for all three presentations: (1) how best to measure and describe experiences of people who are falling through the cracks in the health care system in one way or another, (2)_relevance of these measures to current policy discussions at the state and national level (protecting people from the high cost of prescription drugs, surprise medical bills) , (3) the multiple ways of measuring concepts including literacy and affordability, and (4) Different survey approaches gather different types of information on the same topic, which can be valuable in different ways. Discussant and floor comments highlighted the value of pairing population-level statistics with qualitative information to illustrate people's experiences for policy makers.

General comments from the FLOOR

Brad Edwards (Westat) commented that it is important to establish who is the correct respondent, and look up who is the plan holder. Ashley Kirzinger (KFF) added that she finds that women may be more likely to manage the family healthcare and would be a better respondent. Operationally it would be difficult to get the most knowledgeable person as the respondent.

II. Specific comments to each of the three presenters:

Specific comments for Kathleen from Liz

Do either likelihood or confidence measure actual literacy? Are there other measures out there? Can we match up comprehension with actual policy terms, e.g. deductibles? Isn't it surprising that heavy users don't have higher likelihood? Kathleen responded that she is skeptical about whether we can measure health insurance literacy. An intervention in coverage would be more informative about the performance of the measure. State policy makers are primarily interested in people who would use no-cost public options but believe that there are costs.

Specific comments for Kathleen from the FLOOR

Participants in the discussion pointed out that the U.S. Health Insurance system has gotten so complicated that it is difficult for people to be Health Insurance Literate (HIL). Brad Edwards (Westat) noted people often think something like nursing home care is going to be covered and only learn that it is not covered when the need for nursing home care arises. This makes them feel less confidence despite having greater knowledge, while those who have not used the insurance may be over-confident. Based on experience with the MEPS-IC that surveys employers about health plans they offer their employees, Alice Zawacki (Census) added that employers lack understanding both of insurance policy terms and markets, in some cases not even knowing that payments are tax exempt. The overwhelming conclusion was the US health insurance system is too complicated and needs to be simplified.

Kathleen's presentation found that the "Likelihood" and "Confidence" Health Insurance Literacy (HIL) measures were associated with access to care but that those reporting higher "Likelihood" of performing insurance tasks have higher odds of forgoing routine and specialist care due to costs. Brad Edwards (Westat) brought up the terms "burned and hesitant" that he and others had discussed earlier

as a possible explanation in describing people who think something is going to be covered and have learned it isn't resulting in their higher odds of forgoing routine and specialist care due to costs.

In trying to access a person's HIL, Brad Edwards (Westat) mentioned it is important to know who would be the best respondent (noted above under General comments from the FLOOR.) Another participant pointed out that when the survey is deployed relative to open season may also be relevant in terms of persons recent review of their health insurance plans and thereby being more knowledgeable of their health insurance policy benefits. Stephanie Eckman (RTI) asked about the rationale behind oversampling prepaid phones. Kathleen noted that prepaid phones are oversampled because those people were more likely to be uninsured and there is a flag on the RDD frames indicating which ones are prepaid phones.

Participants pointed out that we want to know HIL but the current measures are highly influenced by experience and access to care. A possible way of measuring HIL that may not depend as much on experience would be to ask specific knowledge questions. Stephen Blumberg (CDC) reaffirmed the importance of knowing about literacy, perhaps by focusing more on actual comprehension of terms, such as asking people what is their deductible. Kathleen noted that Urban Institute in their Health Reform Medical Survey (HRMS) played with a bunch of questions and learned that high utilizers may know but others will not know their plan's deductible. It was also noted that the MCBS has a series of health insurance knowledge questions for Medicare. Kathleen also noted that measures of satisfaction with health plans also depend on attempted use. Ashley Kirzinger (KFF) summed it up as people tend to grade their coverage highly, but also take it for granted, unless they have actually had to use it.

Todd Rockwood (UMN) suggested another way of measuring HIL that may not depend as much on experience is by having people only report at salient change points. We could walk them down a chain of questions depending on whether or not they recently had certain experiences via a subtraction approach. It was noted that we would then only have information for people with certain experiences. Kristen Olsen (U Nebraska) suggested measuring likelihood of use over some timeframe and to ask about how recently they had events like changes of insurance or doctors. Kathleen responded that it may be costly but there may be existing data from a variety of measures that can be compared.

Matthew McIntyre (23andMe) wondered whether non-survey approaches, such as reviewing policy documents would be a way of getting health insurance benefit information not influenced by experience. Alisha Simon (MN Dept of Health) noted that there is no way to match insurance policies to respondents in most markets. Most plans in some markets are self-insured. Could possibly do this for a limited universe such as those with Medicare or Medicare Advantage. Brad Edwards (Westat) noted that MEPS tried to get people's health policy booklets and are now trying to do this via a portal, but it's not working very well. Frances Chevarley (Retired, AHRQ) asked whether getting information from people's health insurance cards may be helpful. Stephen Blumberg (CDC) reported getting copies of people's health insurance cards was tried in NHIS and based on their experience, it doesn't help.

The overwhelming conclusion was the US health insurance system is too complicated and needs to be simplified.

Specific comments for Ashley from Liz

Both Ashley and Liz noted that KFF is looking for feedback from the floor.

Specific comments for Ashley from the FLOOR

In Ashley's presentation she noted differences in estimates for similar NHIS and a KFF questions on problems in paying medical bills. In her presentation, Ashley noted differences in the question wording as well as survey differences such as response rates, mode differences, sampling, survey sponsors, and context.

Concerning differences in question wording, Jared Jobe (Independent Consultant) mentioned that with focus groups one would want these questions to include people with high bills and can't pay as well as those who are avoiding financial burden by not seeking care. Ashley agrees with this point. Jared also emphasized that the overall context of the survey is important and the order of the questions is important since respondents exclude information in previous questions.

Stephen Blumberg (CDC) noted that the NHIS question is on their minds because of the 2019 NHIS redesign. It was noted that the NHIS question lists the types of medical events after the question is asked; the KFF includes the types of medical events as part of the question. Having the types of medical events listed after the question is read is not good since respondents will be attempting to answer the question before the list is read. Joanne Pascale (Census) wondered whether the number of examples built into the question and separation with spaces could be affecting how much of these are read. Jen Dykema (UWSC) noted it has been shown that respondents interrupt and interviewers may not read the full question in up to 30% of interviews. Didem Bernard (AHRQ) added that the list of types of medical events can evoke memories of medical events and bills in the respondent, so delivering them differently could have a big effect. Stephen Blumberg (CDC) mentioned that they addressed this issue in the 2019 NHIS redesign. In the 2019 redesign the list of types of medical events is no longer after the question but is before the question. Ashley Kirzinger (KFF) noted that who the respondent is can make a difference. The person who picks up the phone reports on the household in KFF. Stephen Blumberg (CDC) noted that the 2019 NHIS redesign question is asked of the sample adult; the question had previously been asked of the family respondent. NCHS is awaiting the 2019 redesign data for this question. Ashley Kirzinger (KFF) appreciated learning that the NHIS question was changed in the 2019 redesign and that the 2019 redesign data will be available.

Stephen Blumberg (CDC) noted that order may be important and that the NHIS question is at the end after the health insurance questions. The KFF question is after the attitudes over ACA questions.

Joanne Pascale (Census) commented on the diverging trends for the NHIS question in the NHIS and the KFF question in the KFF. Liz Hamel (KFF) noted that she tends to point people to the NHIS for population-level trend statistics, given the fluctuations in the KFF numbers and that the KFF questions changed slightly over time.

When the NHIS and KFF questions were placed on the same survey, the SSRS Omnibus Survey, Ashley noted the differences in the unweighted estimates were less than the differences in the weighted estimates when the questions were on separate surveys. This demonstrates that all of the differences in estimates from these questions in the NHIS and KFF surveys cannot be attributed to the question wording.

Phillip Hughes (MAHEC) and Fran Chevarley (Retired, AHRQ) noted that different people may be covered in the NHIS question in NHIS and the KFF question in KFF as the NHIS specifically excludes non-family roommates, while the KFF survey does not.

Specific comments for Didem from Liz

Financial burden is an interesting concept because it includes deductibles, co-pays, and premiums. How does burden relate to affordability? What is driving lack of usual source of care? Is it lack of availability or lack of perceived need?

Didem responded that she will go back and see what is driving these patterns.

Specific comments for Didem from the FLOOR

In her presentation, Didem discussed five affordability measures and analyzed each in terms of elderly/non-elderly, insurance status, race/ethnicity, poverty, and by the presence of medical conditions.

Sadeq Chowdhury (AHRQ) noted that many measures are related and encouraged exploration of multivariate models controlling for background factors. Didem said they plan to run those models.

Liz Hamel (KFF) asked why they included food insecurity as one of the affordability measures. Didem explained MEPS has a team and funding to look at social determinants of health measures using MEPS and the food insecurity measure was one of the measures.