

## Flattening the Trajectory of Health Care Spending

# Engage and Empower Consumers



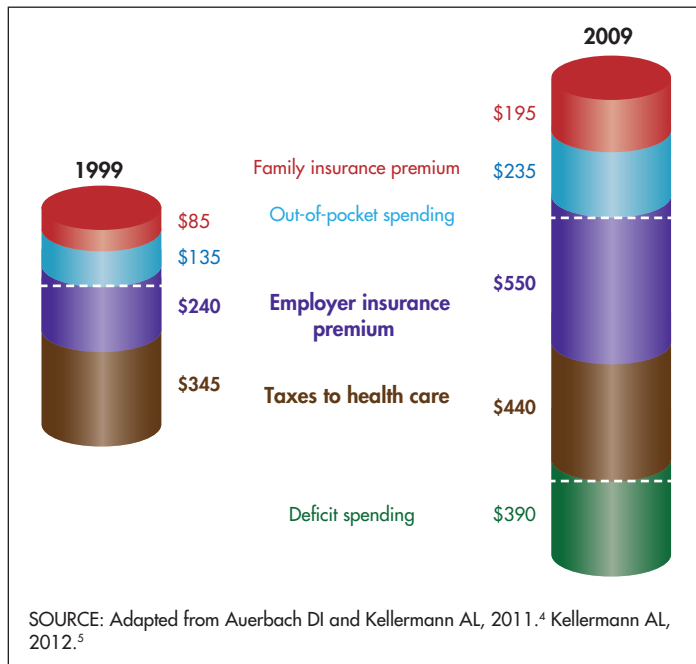
### KEY FINDINGS

- Cost-sharing leads consumers to use less health care, but they tend to reduce highly beneficial and less beneficial care to equal degrees.
- How cost-sharing is managed matters. Otherwise, it can produce unintended consequences.
- Engaging consumers is not enough; they must also be empowered with useful information so that they can make informed decisions.
- To be helpful to consumers, public cost and quality reports must be accurate, accessible, and easily understandable.

### The Policy Challenge

In the past decade, the annual health care costs of an average U.S. family nearly doubled, from \$9,660 to \$17,040.<sup>1</sup> This effectively erased the income gains of middle-income families during this time period.<sup>2, 3</sup> Because consumers play an important role in the growth of health care spending, RAND researchers have explored the promises and pitfalls of numerous approaches intended to encourage them to become more “prudent shoppers” of health care services. This brief presents key findings from RAND research.

**Figure 1. Both Visible and Invisible Health Expenditures Have Grown**



## Engaging Consumers as Partners in Reducing Health Care Spending

Typically, consumers pay for health care in four different ways, two of which are largely hidden from view. Consumers are generally aware of how much they pay out of pocket, and most keep track of the price of their monthly insurance premium. But they are less likely to consider the income they forego to support their employer’s tax-advantaged contribution to their health insurance or the amount of state and federal taxes (roughly 20 percent) they pay to support government-funded health programs, such as Medicaid, Medicare, the Children’s Health Insurance Program, the Veterans Health Administration, and federal and state public health activities. When all four sources of spending are combined, the total is larger than most consumers realize (Figure 1).

**Giving consumers “skin in the game.”** To motivate consumers to play a more active role in controlling health care spending, they need to have a personal stake in their purchasing decisions. The landmark RAND Health Insurance Experiment (HIE) was the first to demonstrate that when consumers are responsible for a portion of their health care bill, they limit their spending by using fewer health care services.<sup>6,7</sup> In the original HIE, patients in the cost-sharing groups reduced use of beneficial and nonbeneficial services to a similar degree without significant ill effects. In the decades that followed, private insurers embraced this observation by implementing a variety of cost-sharing mechanisms to give consumers “skin in the game.”

Recently, a team of RAND and Carnegie Mellon University researchers explored the effects of cost-sharing in today’s health care market by conducting a large-scale, national study of the impact of consumer-directed health plans (CDHPs)—high-deductible health insurance plans that are often paired with tax-advantaged health savings accounts that allow unused funds to be rolled over from one year to the next. In exchange for accepting a significantly higher deductible, employees pay lower monthly premiums. In 2012, 59 percent of large employers offered at least one such plan. Enrollment is expected to grow rapidly.<sup>8</sup>

Proponents of CDHPs contend that they incentivize consumers to use health care more sparingly and select lower-cost treatment options. Critics assert that consumers lack the information they need to make wise choices. They also worry that high co-pays and deductibles may lead consumers to scrimp on high-value medical services. Should this happen, CDHPs could inadvertently drive spending higher because of missed opportunities for prevention and the subsequent need for costly treatment.

To shed light on the controversy, RAND partnered with 53 large U.S. employers to examine how high-deductible plans—particularly CDHPs—affect health care costs and use of care.

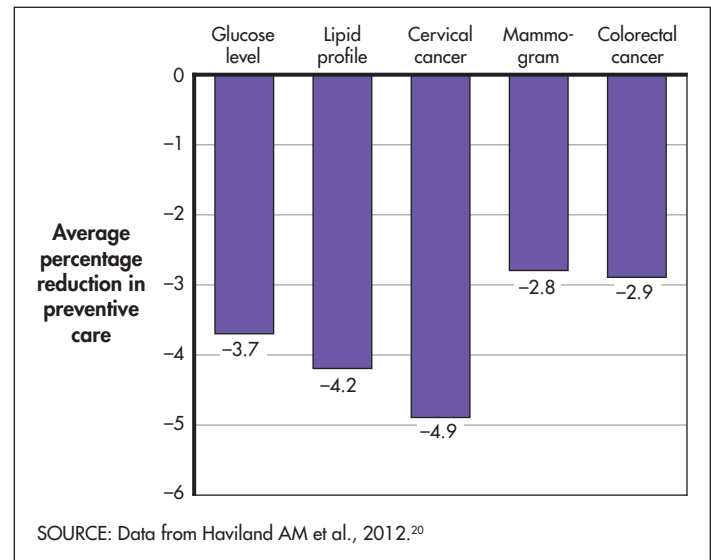
A total of 800,000 households were involved in the study. **Compared with families who remained in a traditional plan, families who switched to a CDHP sharply reduced health care spending during the first year after switching.**<sup>9, 10, 11, 12, 13, 14</sup> The reduction in use of services persisted even after the researchers took possible differences in the underlying health status of group members into consideration. CDHP enrollees with deductibles of at least \$1,000 per family member cut their health care spending the most—an average of 18 percent.<sup>15</sup> Two-thirds of the reduction came from reducing the number of “episodes of care”—encounters with health care providers. The remaining third came from lower spending during each episode—for example, by opting for a less costly generic drug over a brand-name drug.<sup>16</sup>

If CDHPs grow to represent 50 percent of the employer-sponsored insurance market, they could result in annual cost savings of \$57 billion. This is equivalent to a 4-percent reduction in health care spending by the nonelderly.<sup>17</sup> Larger or smaller market shares would generate corresponding differences in savings. It is important to note that these estimates are based on the savings observed in the *first year* of CDHP adoption. Longer follow-up periods are needed to assess the ultimate impact of these plans.

**The level and structure of cost-sharing matter.** Both the HIE and the more recent study of CDHPs found that when consumers reduce their use of health care services, they do not do a particularly good job of distinguishing between highly beneficial and nonbeneficial care. As a result, they tend to cut both across the board. In the HIE, this did not appear to have serious consequences for most patients involved in the study. However, the poorest and sickest 6 percent of participants at the start of the HIE had better outcomes under the free plan for four of the 30 conditions measured, suggesting that this group warrants special attention.

The study of CDHPs produced similar results. Compared with families in more traditional health plans, families who switched to a high-deductible CDHP used fewer high-value preventive services, such as childhood vaccinations, mammograms, and screenings for cervical and colorectal cancer.<sup>18, 19</sup> Use of high-value clinical services, such as blood tests for glucose and cholesterol among diabetics, also fell (see Figure 2).

**Figure 2. Enrollees in Consumer-Directed Plans Received Less Preventive Care, Compared with Consumers in Traditional Plans**



Interestingly, these drops in preventive care occurred despite the fact that most of the affected services are *fully covered* under consumer-directed health plans. Either beneficiaries did not know about the preventive care benefit, or reducing their number of episodes of care meant fewer opportunities to receive preventive services. If this pattern of service reductions persists over time, subscribers to CDHPs may run a higher risk of developing serious preventable illness. If that were to happen, it could negate any short-term savings.

Similar notes of caution about cost-sharing were raised by RAND studies that examined how cost-sharing affects drug usage, costs, and health.<sup>21</sup> When consumers with chronic illnesses faced higher cost-sharing for their drugs, many cut back on their doses, stopped taking a recommended medication, or delayed starting a new prescription for a chronic disease, such as diabetes or high blood pressure. If co-payments for ambulatory care are pushed up too steeply, elderly patients might forgo needed outpatient care.<sup>22</sup> Such behavior might not only land them in an ER—it could increase costly hospitalizations.<sup>23, 24, 25, 26, 27</sup>

Recently, a group of RAND researchers examined how patient cost-sharing affects use of cholesterol-lowering drugs,<sup>28</sup> a commonly prescribed class of medication in the United States with a proven track record for reducing cardiac events and mortality. The team calculated that for every \$10 increase in co-payment, medication compliance fell by an average of 5 percentage points.<sup>29</sup>

Conversely, if high-risk chronic disease patients were given a financial incentive to comply with recommended drug therapy, it might be possible to reduce their use of costly health care services. For example, RAND researchers estimated that if sicker consumers faced no co-payment for high-value medicine and low-risk patients faced only a modest increase in their medication co-payment, it could decrease preventable hospitalizations by 80,000 to 90,000 per year and reduce use of emergency departments by 30,000 to 35,000 visits per year, generating annual savings of roughly \$1 billion.<sup>30</sup>

Another study went further and suggested that insurers may want to go beyond eliminating co-payments for statins and develop programs to promote their use by untreated patients with high cholesterol.<sup>31</sup>

Considered together, these research findings indicate that large co-payments, particularly for high-value services, such as drugs that stop or delay the progression of chronic disease, may produce detrimental effects. Value-based benefit designs, which

impose low or no co-payments on highly beneficial services but increase cost-sharing for expensive services of marginal value, may be more effective than a one-size-fits-all approach.

## Empowering Consumers with Understandable and Actionable Information

To participate effectively in a market-oriented health care system, consumers not only need to be *engaged*; they need to be adequately *informed*. In a seminal article published nearly 50 years ago, Nobel laureate Kenneth Arrow noted that medical care does not behave like a normal market because the seller (the health care provider) has far more information about the product being sold than the buyer (the patient). Economists recognize that “information asymmetry” creates opportunities for the party with more information to exploit the party with less information.<sup>32</sup> Examples abound in the health care industry.<sup>33</sup>

To level the playing field, both public (Medicare, Medicaid) and private payers are attempting to arm health care consumers with information about the cost and quality of hospitals and individual health care providers, based on the assumption that knowledgeable consumers will take this information into account when choosing a provider.<sup>34</sup> One way this is done is through *cost profiling*. A cost profile is a single number or symbol that places a physician on a relative scale of spending. Insurers use such profiles to identify physicians who are higher-cost or lower-cost providers.

Cost profiling is difficult to do fairly. Because of shortcomings in the current methods used to create the cost profiles, they may not yet be reliable enough for providers to endorse and consumers to trust.<sup>35</sup> For example, in one study of a two-tiered (low cost, high cost) classification system that categorized low-cost physicians as those in the lowest 25 percent of all profiles, more than 40 percent of physicians listed in the low-cost group were misclassified.<sup>36</sup> Consumers who used the profile might base their decision on flawed information.

Public reports of quality have been equally challenging to produce. Moreover, when reliable quality data are produced, consumers often complain that the reports are excessively complex and not particularly relevant to their concerns.<sup>37</sup> Recently, a team of RAND researchers considered the current state of public cost and quality reporting and offered several reasons why these reports are not having their intended effect on consumers:<sup>38, 39</sup>

Some consumers have little reason to care about costs. A substantial number of consumers still have first-dollar coverage, so they are not particularly worried about total costs. Many others have only a modest co-pay or deductible, after which full coverage resumes. Even those covered by a high-deductible health plan often exceed the limit of their annual deductible if they experience a major health problem. In all of these instances, responsibility for subsequent spending passes from the consumer to his or her plan.

Reports do not present information that consumers care about. Many of today’s cost reports show total charges or a payer’s reimbursement rate, neither of which is germane to the consumer’s decision. What consumers care about is their personal (i.e., out-of-pocket) cost, since health insurance covers the rest. In addition, consumers often do not understand how cost measures are calculated and presented.<sup>40, 41</sup> Therefore, they may not trust or understand what they see in a report.

Many consumers mistakenly assume that higher-cost providers are higher-quality providers.<sup>42, 43, 44, 45</sup> This raises the possibility that publicly reporting prices (particularly if unaccompanied by objective information about quality) could produce the opposite effect from what is intended. When low-cost providers see their profiles for the first time, some may be tempted to quickly raise their prices to avoid being misperceived as being of lower quality than their competitors.

RAND researchers have proposed several ways to make public reports more meaningful to consumers:

- **Provide stronger financial incentives** by adopting benefit designs that require higher co-payments for high-priced providers or a less costly plan that excludes high-priced providers.
- **Target the choices that consumers make most often.** Generally speaking, consumers do not “shop” for care during a serious illness or major emergency—they follow the guidance of the paramedic or their physician. Consumers are more likely to use reliable cost and quality data when selecting a primary care physician, an obstetric or maternity hospital, or a specialist to perform an elective procedure, such as a colonoscopy or joint replacement.
- **Present cost and quality measures alongside each other** to counter the misperception that higher cost equals higher quality. Providers should be listed in quality tiers and ranked within each tier by cost (see example, Figure 3).

**Figure 3. Proposed Example of a Public Report That Could Better Engage Consumers**

Report Card for Maternity Hospitals		
High Quality Hospitals at a Reasonable Price		
Hospital	Quality of care for deliveries (?)	How much will you pay out of your own pocket? (?)
Kline Memorial Hospital	★★★★★ Excellent	\$100
Pazak Women’s Hospital	★★★★★ Excellent	\$125
Walkowiak Hospital	★★★★ Above average	\$50
Other Hospitals		
Hospital	Quality of care for deliveries (?)	How much will you pay out of your own pocket? (?)
Williams Hospital	★★★★★ Excellent	Click here for detailed information on how the quality ratings were created.
Brown Memorial Hospital	★★★ Average	
Saint Floyd Hospital	★★★ Average	\$300
Simmons Hospital	★★ Below average	\$300
Johnson Memorial Hospital	★★ Below average	\$100

SOURCE: Mehrotra A et al., 2012.<sup>45</sup>

- **In addition to reporting consumers' immediate co-payments, give them an estimate of their total expected cost.** Rather than focusing on only one visit, consumers should have a sense of what the total episode of care will cost, including ancillary fees and follow-up visits.
- **Make sure that consumers can read and understand the information that is presented to them.** Over half of currently uninsured adults—many of whom will become eligible for coverage under the Affordable Care Act (ACA)—have difficulty finding, reading, and understanding basic health information.<sup>46, 47</sup> Provisions in the ACA require health plans seeking certification in state exchanges to provide information in plain language. This means using “language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well-organized, and follows other best practices.”

Conveying health information in understandable language is essential. It not only helps consumers pick health plans and select providers; it helps them understand their treatment plan, instructions for taking medicine, and arrangements for follow-up. Ideally, health information for consumers should be field-tested to ensure that it can be read and understood by its intended audience, even those with limited literacy.

## Conclusion

Consumers have an enormous stake in flattening the trajectory of health care spending because they ultimately bear the burden of rising health care costs. Properly applied, cost-sharing arrangements can motivate consumers to reduce the amount of health services they use and opt for less expensive but equally effective treatments. But cost-sharing arrangements must be carefully designed and monitored; otherwise, they can have detrimental effects on patient health, particularly if the patient is medically fragile and living on a limited income.

To make wise choices about their use of health services, consumers need reliable, useful, and understandable information. Refocusing existing public cost and quality reports by improving their accuracy and readability will go a long way toward achieving this goal.

## Notes

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