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Rethinking Consumerism in Healthcare

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Rethinking Consumerism: Evidence and Limits

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The Rise of "Consumerism"

- Increasing use of high-deductible health plans (HDHPs)
  - Workers enrolled in some type of HDHP plan (source: KFF)
  - 2006: 4%; 2015: 24%
- Popular notion that consumers should have "skin in the game"
- Buying "value" – consumers should consider both price and quality information in health care decisions
- Belief that consumerism and price/quality transparency – will spur system reform

Shopping in Health Care

- Motivation: research on consumerism and "shopping" by Chapin White and co-authors
  - Price transparency efforts could save $100 billion over a decade, $18 billion of this from consumer shopping
  - 1/3 of total health care spending in a given year is shoppable
- HCCI has been looking at "skin in the game"
  - Out-of-pocket public reporting
  - Shoppable services
- Ability to look at the question with a national dataset

What Is the Average Person Paying Out-of-Pocket?

Service Category	Per Capita Out-of-Pocket Spending in 2010	Per Capita Out-of-Pocket Spending in 2014	Average Annual Change in OOP Spending Growth 2010-2014
Acute Inpatient	$43	$50	4.2%
Outpatient Visits	$98	$137	8.7%
Outpatient-Other	$68	$92	7.8%
Professional Services	$299	$366	5.1%
Brand Prescriptions	$101	$67	-9.8%
Generic Prescriptions	$91	$98	2.0%
Total Out-of-Pocket	$701	$810	3.4%

Note: The OOP averages include patients with zero healthcare spending.
Source: *2014 Health Care Cost and Utilization Report*, HCCI 2015.

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Spending on Shoppable Services

- We believe that the availability of price and quality information for consumers is important
- "Shoppable" services must be researchable in advance, multiple service providers need to exist in a market (competition), sufficient pricing data
- HCCI's replication of the White and Eguchi study
  - 73 DRG-based admissions
  - 277 CPT or HCPCS codes
- Analysis suggests an upper-bounds on the effect of consumerism

Can the Tail Wag the Dog?

High-Level Findings:

- At most, 43% of the $524.2 billion spent on health care by individuals with ESI in 2011 was spent on shoppable services
- About 15% of total spending in 2011 was spent by consumers out-of-pocket
- $37.7 billion (7% of total spending) of the out-of-pocket spending in 2011 was on shoppable services

Of the Out-of-Pocket $37.7 Billion…

- Copayments
  - Often a fixed fee for a service
  - $8.6 billion
- Coinsurance payments
  - 27% of the out-of-pocket spending for shoppable services was for coinsurance payments
  - $10.2 billion
- Deductible payments
  - Payments for deductibles accounted for nearly 50% of the dollars spent out of pocket on shoppable services
  - $18.9 billion

Institutional Constraints on Consumerism

- Availability of care – are there multiple sources
- Market features
  - Insurer concentration
  - Geographic location
- Price variation
- Benefit design
  - Features of benefit designs
  - HDHPs

Patient Constraints on Consumerism

- Limited evidence most patients want to be Uber-consumers
- Shopping not always desirable
  - Integrated care
  - Relationships between patients and providers
  - 5% or patients, 50% of health care dollars
  - Prescriptions
- Many services that are hypothetically shoppable are consumed once patient is in the “system” either at a doctor’s office or a hospital/facility
- Some consumers want to consume convenience

The Effects of Consumerism

- The shift to consumerism assumes that consumers are willing to take up this responsibility
- Overall, the potential gains from the consumer price shopping aspect of price transparency efforts are modest – not to say that overall effect is not substantial
- Efforts at reform should focus on
  - Providers
  - Payers
  - Employers
  - Other stakeholders

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The New Consumerism

Chapin White

April 21, 2016

The views expressed are those of the author, not RAND or its funders.

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The New Consumerism

Chapin White

April 21, 2016

Preview

- Context
- Evidence on effects of cost sharing
- A New Consumerism

Cost Sharing: The Policy Spectrum

Proposal #1: Universal public coverage, no cost sharing	Proposal #2: Public and/or private plans, income-based cost sharing		Proposal #3: Catastrophic coverage for all
T. Kennedy	Javits	Nixon	Long, Ribicoff
Conyers	Reich	Obama	
Sanders		H. Clinton	Hagopian and Goldman

Argument for Cost Sharing	Evidence
• Reduced “moral hazard,” less waste	

Does Cost Sharing Reduce Waste?

- Yes, but …

RAND Health Insurance Experiment (HIE)

- Cost sharing reduced episodes of care
  - reduced episodes of ineffective treatment
  - and, reduced episodes of highly effective treatments

RAND Health Insurance Experiment (HIE)

- Cost sharing reduced emergency dept. visits
  - 47% reduction for less urgent problems
  - and, 23% reduction for more urgent problems

RAND Health Insurance Experiment (HIE)

- Any cost sharing (>$0) more important than amount

Pharmaceuticals

- Cost sharing reduces use of essential drugs
  - → increased emergency department visits and hospitalizations
  - → increases overall costs

Medicaid Expansions

- Reduce mortality
- Improve diagnosis and treatment of diabetes
- Improve mental health outcomes

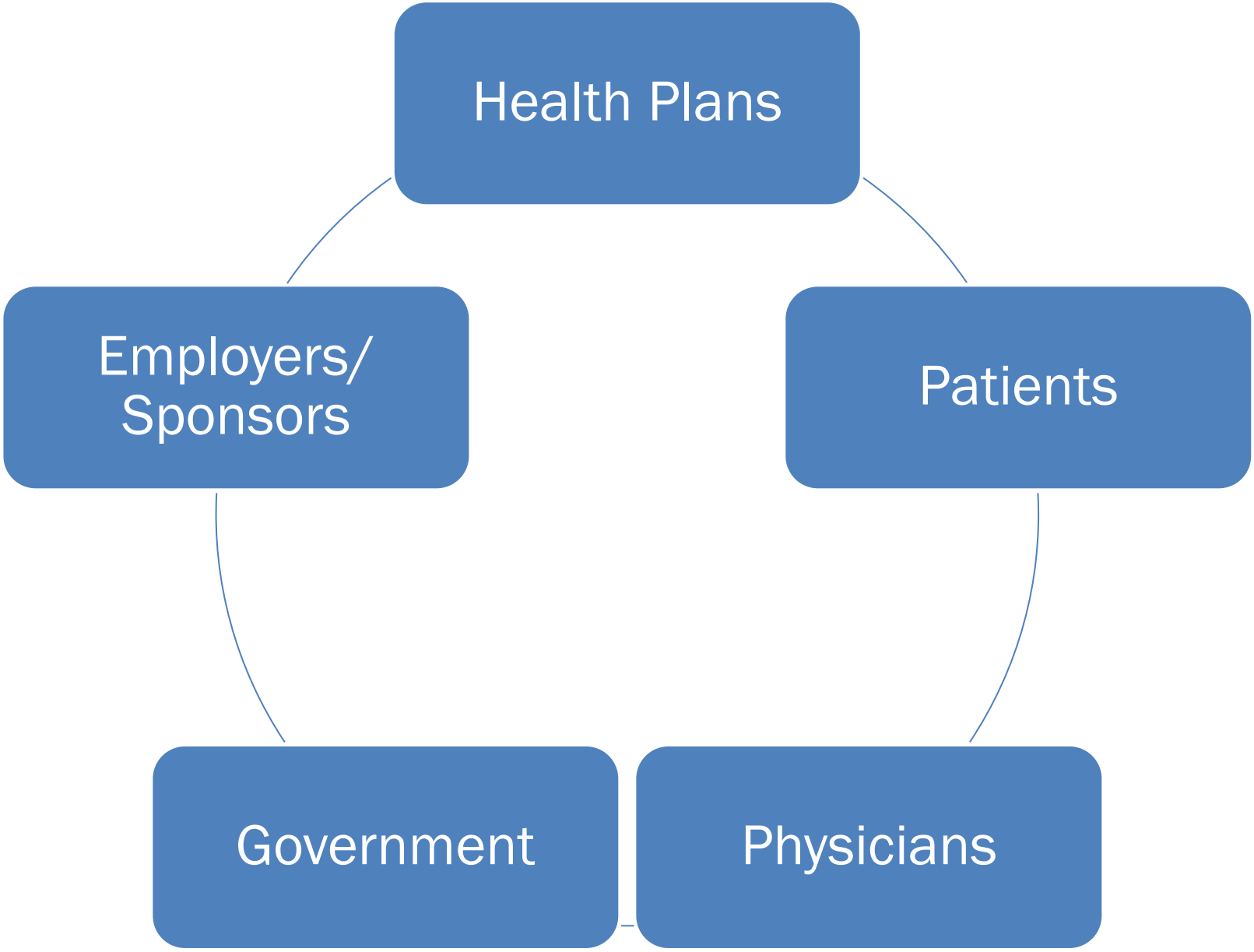
Argument for Cost Sharing	Evidence
• Reduced “moral hazard,” less waste	• “A Blunt Instrument”

Argument for Cost Sharing	Evidence
• Reduced "moral hazard," less waste	• "A Blunt Instrument"
• Less redistribution	✓✓

The New Consumerism

- Shopping for health care is a team sport
- Different players have different roles

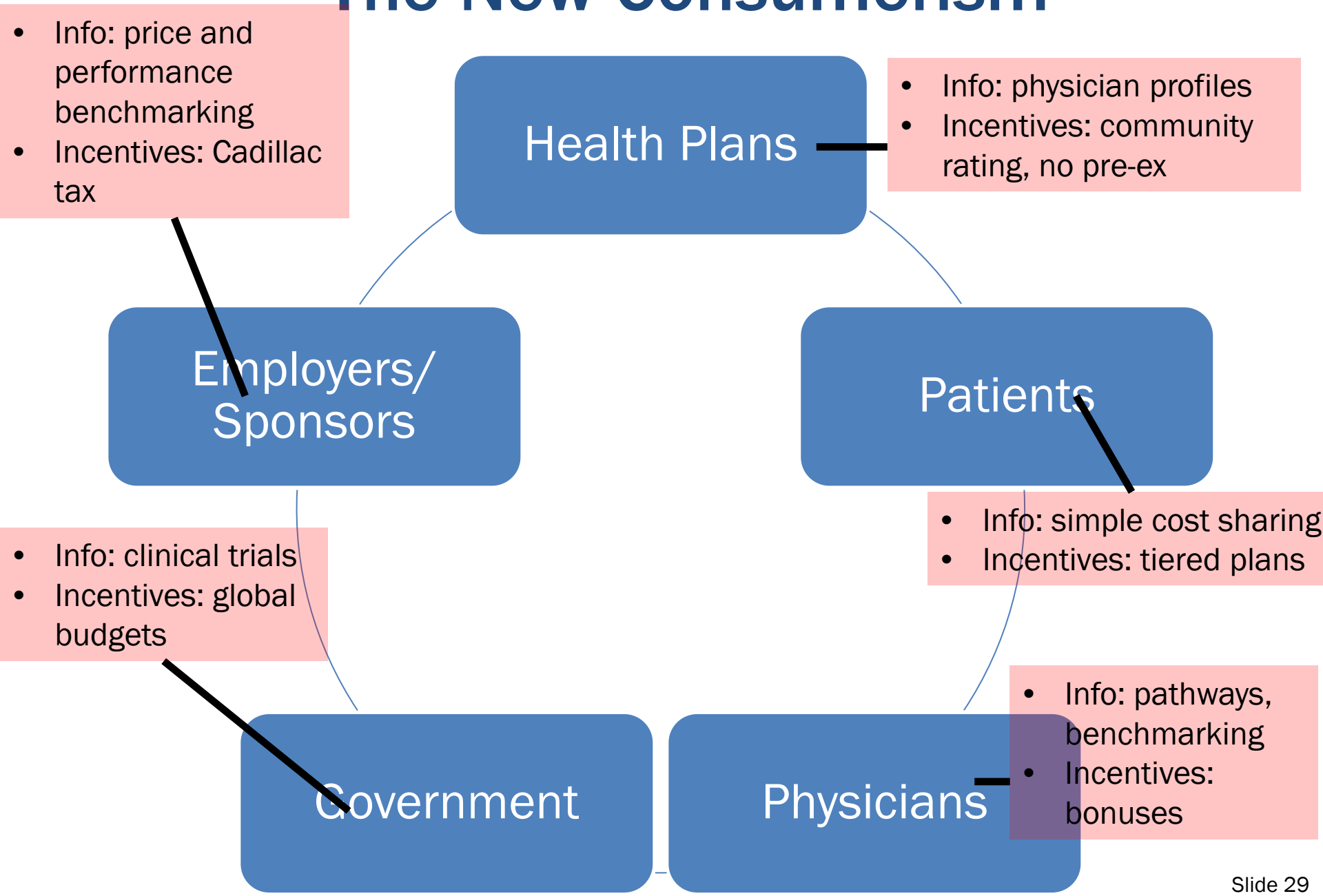
The New Consumerism



The New Consumerism

- Shopping for health care is a team sport
- Different players have different roles
- What information do they need?
- Can better incentives can up their game?

The New Consumerism



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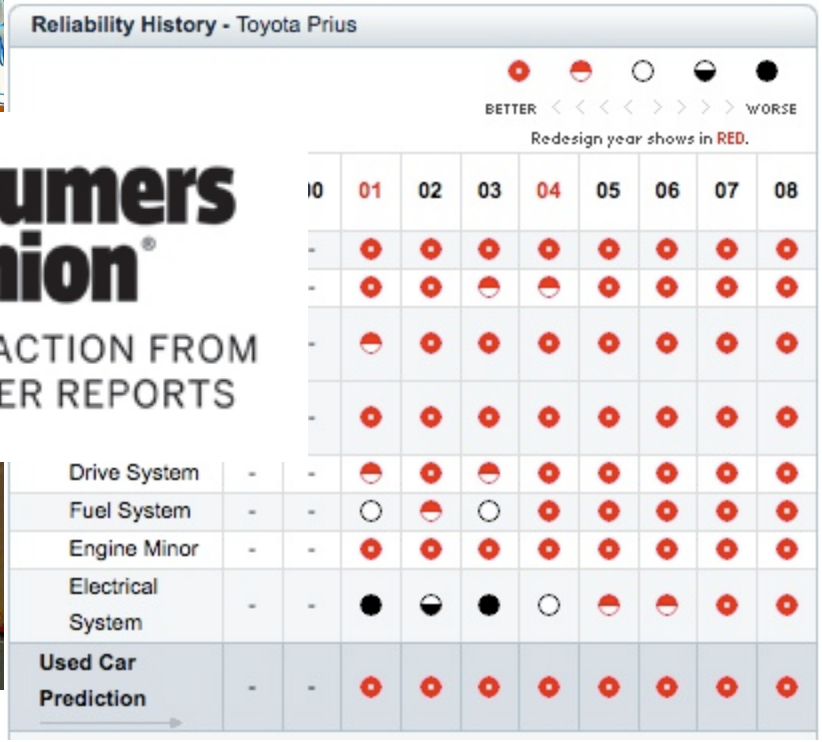
Rethinking Consumerism in Healthcare

Lynn Quincy, Director
April 21, 2016
@LynnQuincy

Yes, THAT *Consumer Reports*



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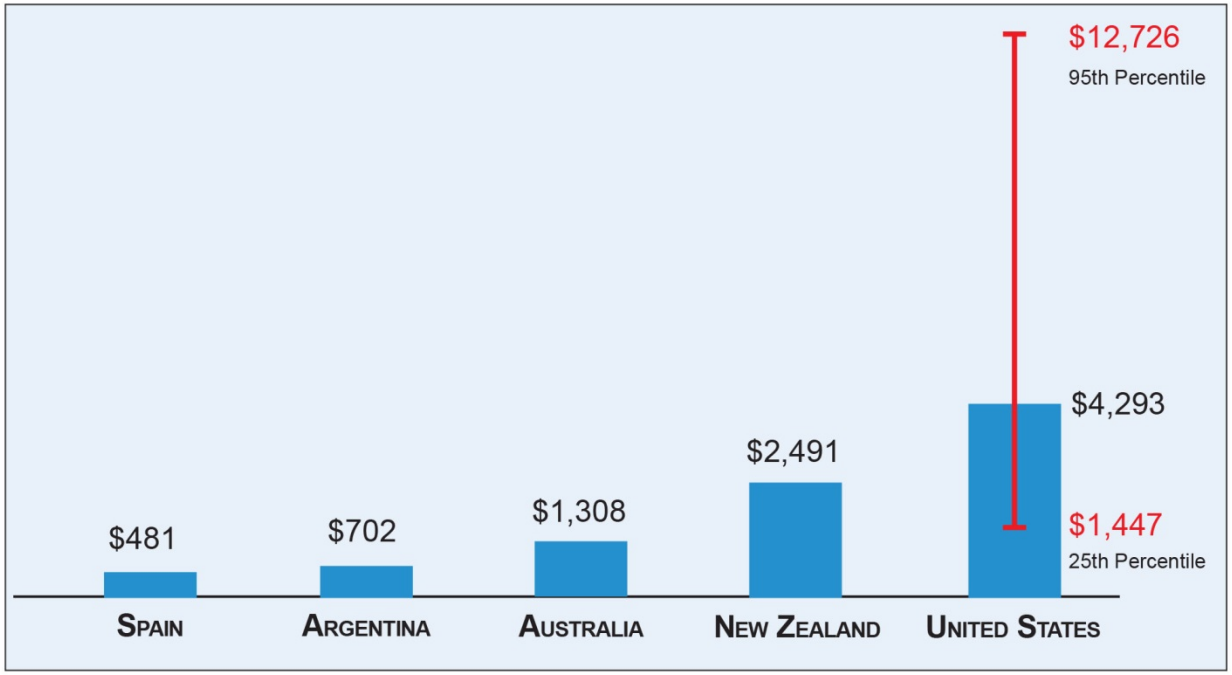
Best Buy Drugs

Healthcare in U.S. is Very Expensive

Few families can pay out of pocket for a serious illness.

Most need health insurance but not everyone can afford it.

Average Hospital Cost per Day, 2013



Source: *2013 Comparative Price Report,* International Federation of Health Plans

What is payers main response?

High deductible health plans.

These plans don’t work.

What does the evidence say about High Deductible Health Plans (HDHPs)?

Compared to more generous coverage, premiums are lower BUT:

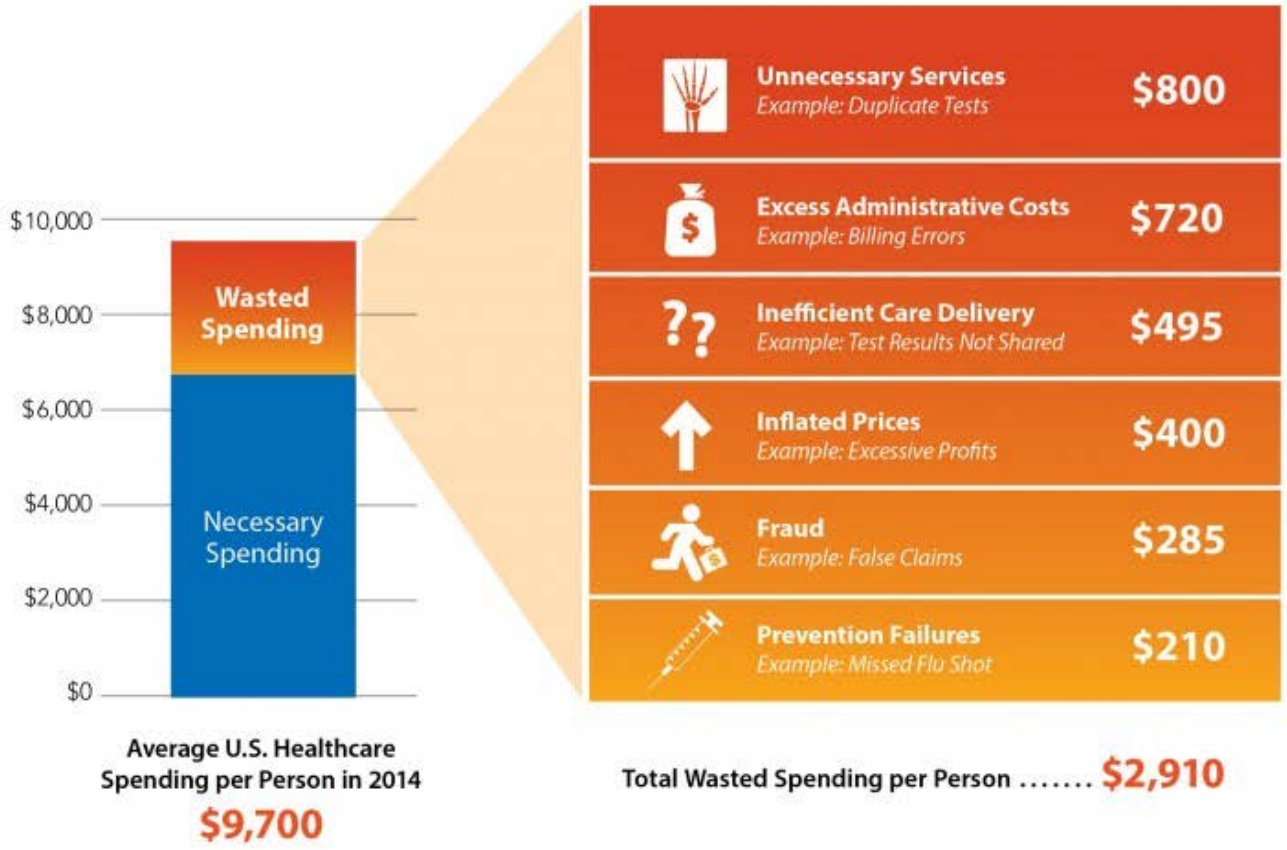
- Patients reduce both necessary and unnecessary care
- Patients don't price shop
- Patients don't shop based on quality

Other evidence suggests WHY consumers don't price shop:

- Care is rarely labeled as high-value or low-value
- Patients rarely know the price of a service and providers are often unable to help
- Patients rarely know quality or likely outcomes between two treatments.
- Consumers don't view healthcare as a commodity.

Approximately 1 in 3 Health Care Dollars is Waste

Can We Afford This?



Average U.S. Healthcare Spending per Person in 2014

$9,700

Total Wasted Spending per Person $2,910

Consumers are harmed by healthcare costs they can't afford

22 percent of the privately insured are *under*-insured. When patients can't afford care, they:

- Cut back on care.
- Cut back on other critical spending like rent and groceries
- File for medical bankruptcy
- Suffer stress, anxiety and poor health outcomes

No wonder: concerns about affording healthcare are number one worry for consumers

What's the Bottom Line?

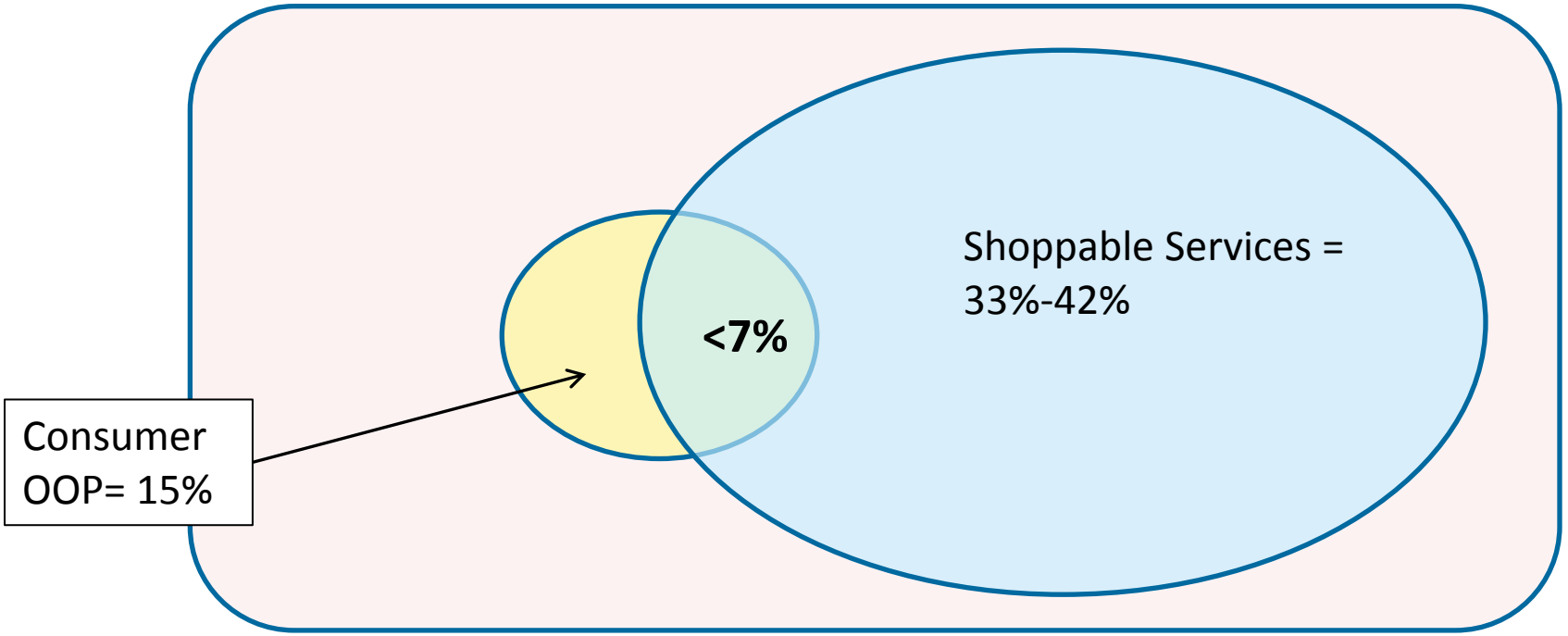
HDHPs are the WRONG approach to addressing high health care costs

Providers need to be the focus of cost-containment efforts

HDHPs need to be replaced with more consumer-centric, evidence-based benefit designs:

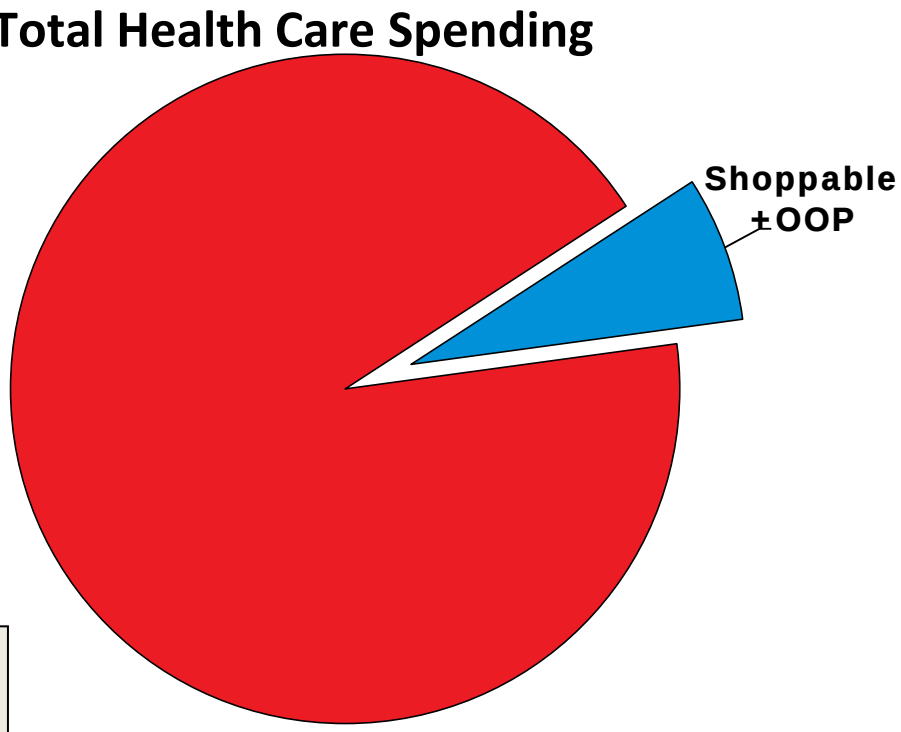
- VBID
- Reference Pricing
- High value provider networks
- Strong provider and treatment-specific quality signals
- Affordable cost-sharing

To recap: Less than 7% of total private health spending is “shoppable” and paid out-of-pocket by consumers



Sources: *Spending on Shoppable Services in Health Care*, HCCI, March 2016 and White and Eguchi, *Reference Pricing: A Small Piece of the Health Care Price and Quality Puzzle*, NIHCR Research Brief No. 18 (October 2014).

Most Health Care Dollars Are Directed by Physicians



The most expensive piece of medical equipment is a doctor's pen.

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RESEARCH BRIEF NO. 11 | APRIL 2016

Rethinking Consumerism in Healthcare Benefit Design

High healthcare costs are a concern for consumers and payers alike. Insurance premiums have risen faster than wages and the economy in general for nearly two decades. High levels of health spending crowds out other important spending. For households, this means lower wages and less money for competing priorities. For state and national governments, it means less to spend on education, infrastructure and other public needs. There is consensus that we can cut back on waste in the system (including prices that are too high) in order to reduce spending without harming our health outcomes.

An oft-used strategy to address high healthcare costs are insurance products called high-deductible health plans, or more generally, consumer-directed healthcare. The basic idea is that by requiring consumers to pay substantial cost sharing these plan designs will incentivize consumers' to extract better value from the healthcare marketplace, helping to stem the tide of rising healthcare costs and reducing the use of low-value care. Nearly half of Americans with employer-provided insurance were required to meet an individual deductible of more than $1,000 in 2015, and many plans go much higher, with deductibles in the $5,000-$6,500 range.[1]

There's just one problem—we have little evidence to suggest that these high-deductible plan designs work. To control spending and bring better value to our healthcare system, we need a new vision for what the consumer's role should be.

SUMMARY

For decades, rising healthcare costs have strained household, employer and government budgets. A strategy often proposed to address these high costs is to give consumers more "skin in the game," through high-deductible health plans. When accompanied by shopping aids, these plans are sometimes called consumer-directed health plans. But a wealth of evidence suggests that high-deductible health plans are not leading to better value in our healthcare system. What's more, unaffordable cost sharing causes considerable consumer harm. Instead, efforts to address high prices and promote high-value care must have a strong provider-directed component, because providers direct treatment plans and steer almost all of our healthcare spending. Our country needs to rethink the role of the consumer in healthcare to be fair, patient-centric and evidence-based. Consumers should be empowered with timely, accurate and actionable information to help make decisions about their care and not have their choices curtailed due to unaffordable cost sharing.

The Theory Behind Consumer-Directed Healthcare and High-Deductible Health Plans

Whether described as a high-deductible health plan or consumer-directed healthcare—either paired with a tax advantaged account like an HRA or an HSA[2] or not--the theory is the same: If consumers face the consequences of their health spending they will spend their dollars more wisely. With up to 30 percent of healthcare spending classified as "waste" by the Institute of Medicine,[3] the goal is for consumers to cut out unnecessary or "wasteful" spending and put downward pressure on prices.

Even When These Plans Save Money, It's Not Because Enrollees Become Wise Shoppers

High-deductible health plans have been associated with lower premiums (compared to plans featuring lower

Consumers should not have to bear the brunt of poorly functioning health care markets that don't deliver value.

-Rethinking Consumerism In Benefit Design,
Consumer Reports, 2016

Thank you!

Contact Lynn Quincy at lquincy@consumer.org
with your follow-up questions.

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