

Can Consumers Be Smarter Health Care Shoppers in the Quest for Cost Containment?

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Lawmakers, health plans, and employers are increasingly shifting a greater portion of health care costs onto consumers in hopes that increased price sensitivity will make them become better health care shoppers. However, health care consumerism offers limited potential for system-wide cost containment and presents significant pitfalls for patients.

Health care spending in the United States has grown rapidly relative to the economy over the past several decades. It has exceeded average annual US gross domestic product (GDP) growth, equaling 17.8% of the GDP in 2015—an increase from 10.2% 30 years earlier [1, 2]. In response to growing health care costs, insurance carriers, purchasers, and lawmakers alike have increasingly sought to manage spending by controlling consumer health care utilization. Health care prices vary widely across markets and providers, seemingly without a clear and consistent relationship to quality [3]. Some efforts have therefore embraced health care consumerism, encouraging patients to become better health care “shoppers.” At the heart of these efforts are fundamental assumptions that cost containment can be achieved if consumers shoulder a greater share of costs, avoid unnecessary care, and shop for low-cost, high-quality providers and services.

However, these efforts have not been successful at pursuing value in health care—that is, promoting better quality and/or health outcomes while controlling costs. In fact, high cost-sharing may worsen health outcomes and jeopardize long-term cost containment in the pursuit of short-term financial savings. Our health care system offers consumers little infrastructure for meaningful health care shopping, and most health care services are not actually “shoppable.” Targeted application of health care consumerism in benefit design may reap savings in limited circumstances, but enthusiasts should temper expectations for consumerism’s impact on containing overall health care costs.

Sharing Costs to Make Patients Shop (But Do They?)

Since 2012, the percentage of workers covered by a plan with a deductible of \$1,000 or greater has grown from 34% to 51% [4]. By exposing consumers to the actual cost of health care services at the point of utilization, high-deduct-

ible health plans (HDHPs) aim to cultivate price sensitivity and prudence among consumers. If they know that they will pay higher costs when they go to the doctor, consumers may avoid unnecessary and low-value care, as well as shop around for lower-cost providers—or so the thinking goes.

Evidence suggests that HDHPs are certainly successful at one thing: reducing the use of health care services. In the most extensive health insurance cost-sharing experiment conducted in the United States, RAND researchers found that increased cost-sharing produced cost savings. However, RAND’s Health Insurance Experiment (HIE) found that savings stemmed not from consumers shopping for lower-cost services but from consumers using fewer services altogether. Higher levels of cost-sharing drove patients to have 1–2 fewer outpatient visits a year and 20% fewer hospitalizations, with similar trends observed for dental visits, mental health treatment, and prescriptions [5].

Another study found by switching its employees’ coverage to an HDHP, a firm reduced health care spending by 10% to 15% over 2 years. These savings were also driven by reductions in care utilization, with the authors finding “no evidence of consumers’ shopping for care and substituting lower-cost services” [1]. A recent survey found that HDHP enrollees were “no more likely than enrollees in traditional plans to consider going to another health care professional for their care or to compare out-of-pocket cost differences across health care professionals” [6].

The High-Deductible Health Plan as a Blunt Instrument

Studies suggest that HDHPs neither encourage enrollees to shop for care, nor incentivize them to consume care more wisely by avoiding unnecessary and low-value care. Sometimes called a “blunt instrument,” the HDHP reduces care across the value spectrum. The RAND HIE found that cost-sharing “reduced the use of effective and less-effective care across the board” and did not alter the proportion of

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inappropriate hospitalizations among enrollees [5]. Another study found that enrollees in HDHPs reduced utilization of preventive care, including childhood vaccinations, mammography, as well as colorectal and cervical cancer screenings [7]. Even when HDHPs exempted high-value services like preventive health screenings from cost-sharing, enrollees in those plans still utilized preventive services at lower rates [5, 8].

One study tracked a firm that switched from a traditional Preferred Provider Organization (PPO) plan to a consumer-directed health plan (a HDHP paired with employer contributions to a tax-advantaged account). After 4 years, enrollees experienced a reduction in outpatient office visits and prescriptions filled. However, there was a slight increase in emergency department visits. This led researchers to speculate that higher cost-sharing reduced patients' use of

outpatient visits, which in turn led to fewer prescribed medications, the long-term consequences of which could have driven patients with chronic conditions to high-cost emergency departments [8].

Similarly, another study found that among patients prescribed cholesterol-lowering drugs, average compliance fell by 5 percentage points for each \$10 increase in copays. The researchers also found that "partial compliance or noncompliance results in greater use of expensive medical services, such as hospitalizations and emergency departments." The researchers conclude that lowering out-of-pocket costs for patients would actually produce net savings by reducing expensive hospitalizations and emergency department use [9].

These studies suggest that the reductions in high-value and effective services use associated with high-deductible

health plans could negatively affect patient health outcomes and increase the likelihood of avoidable, high-cost care utilization over time. If consumers are simply reducing their use of care in HDHPs instead of shopping, it suggests that HDHPs avoid—rather than target—provider prices as principal drivers of system cost growth.

Disproportionate Harm to Vulnerable Patients

While offering little promise for containing health care costs, HDHPs may threaten the care and finances of vulnerable populations. Cost-sharing tends to cause reductions in care, even among those who desperately need it. Studies have found that medical spending reductions are more pronounced among sicker HDHP enrollees than others, adults and children in families with chronic conditions are more likely to delay care when enrolled in an HDHP, and HDHP enrollees are more likely to stop taking medications for chronic illnesses [1].

Consumers with low incomes are more likely than others to forgo care due to the large, upfront out-of-pocket costs that HDHPs require of patients. One study found that consumers living in high-poverty areas with low education rates had fewer high-severity emergency department visits under HDHPs [1]. In other words, low-income communities are less likely to seek needed emergency care when they know they will face a large bill for that care. Unsurprisingly, RAND's HIE found that HDHPs adversely affected health outcomes among patients with low incomes and those with chronic conditions [5].

In addition, the financial health of vulnerable consumers suffers under HDHPs. Roughly half of families with chronic conditions enrolled in HDHPs reported financial burden due to health care costs, compared to only 21% in traditional plans [10]. Families with low incomes enrolled in HDHPs are nearly twice as likely as those enrolled in traditional plans to spend more than 3% of their income on out-of-pocket health

care expenses (excluding premiums) [10].

A mere 5% of the population accounted for half of all US health care spending in 2014 [2]. While these higher utilizers of care drive most of our spending, the HDHP is ineffective at containing costs among this population.

In the RAND HIE, the cost-sharing reduced utilization was primarily due to “participants deciding not to initiate care” [5]. They found that once patients began utilizing care, cost-sharing “only modestly affected the intensity or cost of an episode of care” [5]. After all, if a patient anticipates high health care spending each year up to an out-of-pocket maximum, they lack meaningful financial incentive to shop. It is reasonable to conclude that cost-sharing may not be an effective tool for encouraging shopping or reducing spending among the highest spenders.

Supports and Tools for Consumer Shopping

As previously illustrated, giving consumers more “skin in the game” through increased cost-sharing does not drive them to shop for health care services. However, it is reasonable to question whether consumers could be better equipped to shop for health care if they had decision-making supports. After all, how does a consumer know which in-network providers offer lower prices, which facilities provide higher quality care, or whether a specific health care service is necessary or unnecessary?

In an effort to make these benefit designs work, plans and purchasers are increasingly investing in consumer shopping support tools, such as publicly available price transparency tools and provider quality ratings. However, despite these efforts, very few consumers actually utilize this information. For instance, health insurer Aetna offered a price transparency tool to 94% of its commercial enrollees, but only 3.5% used it over a 1-year period [11].

Even when consumers do encounter pricing information, they seldom use it. One study found that only 13% of consumers sought out any information about prices before seeking care, and only 3% compared costs among available providers [12]. The same goes for quality information: according to a Kaiser Family Foundation poll [13], only 13% of Americans have ever encountered quality information on hospitals, and only 4% have actually used it. Even when used by consumers facing high cost-sharing, the tools have had only a minimal impact on spending [14, 15].

Several factors may explain minimal utilization of these tools and, by extension, why few patients shop for health care. For one, consumers base health care decision-making on other factors beyond price, including location, reputation, referrals, and existing provider-patient relationships [13, 14]. Support tools are also far from perfect: only half of all price transparency tools include information about quality, leaving consumers at risk of worrying that paying less means getting less [14]. Perhaps most importantly, consumers can only shop for a fraction of the health care services they use.

How Much of Our Health Care Can We Shop For?

In order for a consumer to shop for health care services, 3 criteria must be met: the service must be typically scheduled in advance, multiple providers in a market must be available to perform the service, and provider price data for the relevant services must be available [3, 16]. Using this definition, between roughly one-third [3] and two-fifths [16] of our health care spending is on shoppable services. While prices for services that consumers cannot shop for vary more widely than shoppable services, prices for shoppable services differ enough to suggest some limited potential for cost savings [17].

Simply increasing cost-sharing and providing consumer support tools has thus far proven insufficient to generate savings on shoppable services. However, arrangements in which payers simplify shopping decisions for enrollees have shown more promise. For instance, under reference pricing arrangements, payers can target spending on specific shoppable services by giving enrollees information about which providers meet price targets and quality metrics for those services. The payer then sets an upper payment limit for the specific service (the reference price) and provides support to consumers to equip them to find a designated, in-network provider for the service. A hallmark California Public Employees’ Retirement System (CalPERS) reference pricing program successfully redirected patient volumes toward high-value providers, leading to significant reductions in billed charges for target services [18].

However, many hurdles stand in the way of widespread reference pricing implementation. The overall savings potential is modest, few plans and purchasers have reliable provider pricing and quality data for specific services, administration adds new layers of complexity for patients who may already struggle to understand their plan’s benefit design, and payers would need to make significant investments into customer support and education [3]. Moreover, research on reference pricing is limited, meaning that we have not yet fully evaluated the risks for consumers, particularly those with chronic and complex medical conditions. Reference pricing programs could suffer similar flaws as HDHPs, such as high out-of-pocket costs, insufficient provider quality information, and elevated risks for vulnerable consumers [19].

Conclusion

Given the experiments thus far, the role of consumerism in effective health care cost containment is modest at best. High cost-sharing and other tools traditionally employed by plans and purchasers to incentivize consumer shopping have reduced spending in the short term, but they have done so at the risk of reducing utilization of necessary care, worsening health outcomes, and disproportionately burdening low-income and high-need patients. An effective long-term

cost containment strategy must seek to align the objectives of the triple aim, improving the quality of the care experience and improving health outcomes. As of yet, health care consumerism has failed to align these objectives. **NCMJ**

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