TheZetemaProject

Healthcare Consumer Activation Through Transparency and Economic Incentives

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Key Takeaways:

- There have been a number of different kinds of attempts to engage consumers in active and effective shopping for healthcare services, yielding mixed results.
- Some experiments in price transparency have yielded price decreases, but low utilization or high implementation costs have rendered the resulting net benefits negligible or negative, sometimes strongly so. Complicating factors include many consumers seeing higher price as a marker of quality and the weak relationship between charges and the prices patients actually pay.
- High deductible health plans have not been shown to be effective in reducing prices and, in some cases, are associated with discouraging needed care, leading to adverse outcomes.
- Reference pricing, rewards programs, narrow networks, and tiered networks have all had some success in changing consumer behavior to select lower-cost services.
- Consumers do comparatively shop for health plans but premium cost is generally the principle criterion used. The inclusion of deductibles, copays, and coinsurance injects a level of complexity into the products that makes it difficult to comparatively shop.

Price sensitivity and transparency on cost and quality shape consumer behavior in most markets. However, healthcare is not most markets. This paper seeks to answer the question: What is the existing evidence that healthcare consumers can be activated and what can be done to further enable and incentivize them?

Studies show that consumers recognize that there is significant variation in the quality and cost of healthcare services and believe it is important to shop.[1] Even so, a freely functioning consumer market for most healthcare products and services does not exist in the US today. Some would argue that the problem is too much government regulation inhibiting competition, price sensitivity, or transparency. Others might say that healthcare services are difficult or impossible to shop for and the system is too complex for patients to wisely navigate. The problem may be both.

There have been and are examples of reforms that have tried to create markets like this. The results have been mixed.

Transparency

Increasing price transparency was key to the Trump administration's efforts to improve US healthcare. During Trump's presidency, HHS finalized several rules including:

- A requirement effective January 2021 that hospitals publicly post their negotiated rates for basic items and services[2]
- A requirement effective January 2022 that health plans and health insurance issuers in the individual and group markets disclose pricing and cost-sharing information[3]

Efforts are being made to increase price transparency at the state level as well, but progress is varied. Twenty-three states currently have operational all-payer claims databases (APCDs) and several more have enacted legislation to follow suit.[4] APCDs are instrumental in improving data sharing and transparency because the breadth of aggregated information they can provide includes large sample sizes and geographic representation.

Modest decreases in health costs have resulted. As an example, New Hampshire used APCD data to launch NH HealthCost, a public website providing residents with costs at the provider and service levels. Following the launch of NH HealthCost, the negotiated prices for procedures listed on the website declined. Five years after launch, negotiated prices for outpatient medical imaging visits had decreased 4% and out-of-pocket costs had declined 11%.[5]

But these investments are expensive. Researchers point out that while some employers and insurers already provide enrollees with estimates of potential cost, the requirement for real-time data on individual cost-sharing requires far more advanced technical input, management, and compliance.[6] Prior to the implementation of the final rule, the federal government estimated that while insurers and enrollees could save $154 million in reduced medical costs, the three-year average annual burden and cost of implementation of the rule would range between $5.7 billion to $7.9 billion for insurers. The financial burden of this implementation is expected to result in higher premiums in the individual market.

Cost ≠ Quality

It is critical to acknowledge that price and quality are not necessarily aligned.[7] The price of the same service can vary dramatically. Medicare pays physicians and hospitals using administrative prices that are adjusted based on geographic region, indirect medical education, and disproportionate share (providing care to uninsured patients). Variation is marginally tied to quality. Instead, prices paid by private insurers can more often be attributed to bargaining power.

Higher cost can be also viewed by consumers as a proxy for high quality, though the correlation is weak. In this way, price transparency may *increase* costs and encourage *higher* prices.

Interestingly, research has found that people who reported having compared prices were more likely to perceive that higher prices indicate higher quality than those who do not compare at all.[8] Quality is tricky enough for providers to measure, and the ambiguity and complexity are reflected in the consumer experience as well.[9]

Transparency ≠ Consumer Comprehension and Action

Transparency on its own will not automatically translate into widespread behavior change because shopping for services is complex and time-consuming. In the end, transparency will only impact consumer activation if consumers can understand and use the available information to help shape their choices.

Transparency on claims in medical coding, for example, will not immediately result in widespread consumer activation because the prices that are available can be difficult to understand and compare. In New Hampshire, only 8% of those with access to NH Healthcost have used it.[10] This is due in part to the tremendous complexity of insurance billing. A single visit to a healthcare provider results in a charge from the provider to the health plan; a proportion of that bill being paid from the health plan to the provider; and the consumer being held responsible (in some cases) for a copayment to that provider as well. This is all contingent upon where the consumer is in the plan's deductible or out-of-pocket maximum. This complexity presents a considerable challenge even for the savviest of healthcare consumers.

Economic Incentives

There are pockets of the US healthcare system in which price transparency and competition do currently function to keep prices low. Examples include fully-elective procedures such as lasik eye surgery and many cosmetic procedures in which consumers are provided with a package price and confirm their costs in advance. This exposes consumers to provider variation and exerts a strong influence on individual decision making. Providers are aware that patients are paying out of pocket and shopping around and thus compete partly based on price.

For health services covered by insurance, cost sharing is used to increase price sensitivity. This most often refers to changes in copayments, deductibles, and coinsurance. Since copayments are flat fees, rather than a proportion of a service's price, they do not truly increase the consumer's sensitivity to the variations in price for that service. Deductibles and coinsurance present a more substantial opportunity for patients to shop and save.

The following strategies have been used to increase price sensitivity and incentivize smarter shopping, with varying levels of success:

High-deductible Health Plans

High-deductible health plans (HDHPs) have not been shown to restrain healthcare prices or reduce unneeded care.[11] Much of the problem is because 5% of Americans account for 50% of healthcare spending.[12] These patients exceed their deductibles, often early in the benefits year, in which case price ceases to influence their decisions. While the initial hope was that by giving consumers "skin in the game" HDHPs would

spur price shopping for healthcare services, evidence finds that nearly all of the consumer response is decreased utilization of care – and not just wasteful care.[13] This can result in unintended consequences and lead to adverse health outcomes. For example, studies find that increases in cost sharing are associated with increased rates of uncontrolled hypertension and hypercholesterolemia and reduced treatment for children with asthma. Additionally, research finds that cost sharing increases financial burdens for families, causing some to cut back on necessities or borrow money to pay for care.

Reference Pricing

With reference pricing, payers set a maximum reimbursement threshold, or reference price, for shoppable healthcare services. Members are provided with price transparency tools that drive them towards lower-priced care. Those who choose to use providers that exceed the reference price pay the difference out of pocket.[14]

A recent study monitored employee healthcare behavior changes over a two-year period. During the first year, only price transparency tools were offered and the authors confirmed previous findings that health plan members rarely took advantage of this information. But when a reference pricing program was added in the second year, consumers began to shop and prices decreased as a result. Laboratory test prices dropped 27% and imaging test prices decreased 13%. The authors concluded that price tools will capture the attention of consumers only if the consumers have strong financial incentives to shop in the first place.[15]

In another example, the California Public Employees' Retirement System (CalPERS) implemented a reference pricing program for hip and knee replacements. Researchers found that after being exposed to the prices for joint replacement surgery, the number of enrollees who chose low-priced hospitals increased by 21.2% and those who chose high-priced hospitals declined by 34.3%.[16]

Rewards Programs

Rewards programs are a related strategy that create price sensitivity through shared incentives. Unlike reference pricing, which financially penalizes patients for spending more than the reimbursement threshold, rewards programs give consumers money back in the form of premium or out-of-pocket cost reductions in response to them selecting lower-cost providers.[17] Several states have started to implement "Right-to-Shop" laws that require plans to create rewards programs.

New Hampshire was the first state to implement a Right-to-Shop program. Within three years, roughly 90% of program enrollees had shopped at least once, with two-thirds repeat shopping.[18] This resulted in approximately $650 in savings each time the tool was used. In comparison, most insurer transparency tools report an average of 2% engagement.

As additional evidence of the success of rewards programs, researchers evaluated a 2017 employer-based program with more than 250,000 eligible shoppers.[19] Consumers who sought out lower-cost care using available price transparency tools received checks ranging from $25 to $500, depending on how much the cost of services fell below the given threshold. 8.2% of the intervention group used the price shopping tool compared with 1.4% in the comparison group. However, usage of the tool varied from service to service. For example, 18.9% of people in the intervention group used the price shopping tool for MRIs compared with 2.6% in the comparison group, whereas 3.3% of those in the intervention group used the tool for ultrasound examinations compared with 0.9% in the comparison group. The authors found a modest 2.1% reduction overall in prices paid for shoppable services in the intervention group relative to the comparison group, with the greatest effect seen in imaging services, which showed a 4.7% and 2.5% decrease in prices paid for MRIs and ultrasounds, respectively. These results hint at the potential for economic incentives to be used in conjunction with price transparency tools to drive down costs. However, it should also be noted that the savings described in this particular program were dwarfed by the administrative costs of program design and implementation.

Narrow Networks

Results from narrow network programs are also promising. In a narrow network, a health insurance carrier contracts with select doctors and hospitals that charge lower prices, have a track record of quality, or both. In exchange for providing greater volume of business to these providers, insurers negotiate lower prices and pass these savings on to employers and their employees in the form of lower premiums. Researchers found that a plan with narrow physician and hospital networks was 16% cheaper than a plan with broad networks for both, and that narrowing the breadth of just one type of network was associated with a 6-9% percent decrease in premiums.[20] Yet narrow networks provide a clearer example of plan-provider negotiations than of consumerism. One study revealed that 44% of those who bought an ACA plan for the first time were unaware of the network configuration associated with their plan.[21] This lack of consumer understanding can lead to catastrophic out-of-network costs passed on to patients in the form of surprise medical bills.

Tiered Networks

Tiered networks present a less severe form of narrow networks and can be viewed as a potential compromise. Members retain access to a broad network of providers, ranked based on cost and quality, and are encouraged to seek services from level-one providers at the lowest cost share. If members choose to see providers in higher levels, they assume higher out-of-pocket costs. When it comes to total medical spending, a recent study found that enrolling in a tiered-network health plan resulted in a decrease of 5% in total healthcare spending per member per quarter.[22]

Shopping for Healthcare Insurance Plans

Since the implementation of the Marketplaces in 2014, 10-12 million people have enrolled in Marketplace plans annually and large majorities have reported satisfaction with their coverage, choice of providers, and plans overall. Medicare Part D prescription coverage, Medicare Advantage, Medicaid managed care, and individual and small group marketplaces under the ACA have all been designed to put consumers "back in charge." [23]

However, only 50 percent of enrollees nationally found it easy to find the right coverage, and only 41 percent believed it was easy to find an affordable plan. An excess of offerings can result in choice overload.[24] Many consumers continue to struggle with the number and complexity of plan options, limited health insurance literacy, and lack of information.[25] To understand the true cost of a health insurance plan, consumers must calculate often complicated cost sharing values (e.g., deductibles and copayments) to estimate out-of-pocket spending. As a result, cost-conscious but overwhelmed consumers may overly focus on premiums with suboptimal plan choices. Research shows that in many cases consumers are "choosing not to choose." When it comes to health insurance, consumers who can shop and switch are unlikely to do so and instead forego significant potential savings.

Conclusion

Investments are being made to increase transparency. However, a growing body of evidence has shown that transparency alone will not result in consumer activation due to low levels of engagement. Recent efforts to combine price transparency tools with economic incentives have shown promise.

Discussion Questions

- Is more consumerism in healthcare something we should strive for?
- What is needed from providers, payers, and policymakers to create healthcare markets that are more transparent about variation in provider quality and cost?
- In addition to more transparent information on quality and cost, what supports do consumers need to translate that information into effective shopping strategies?
- Despite the fact that there is not a great deal of evidence demonstrating their success in the real world, high-deductible health plans (HDHPs) maintain political momentum. Are HDHPs fundamentally flawed tools, or does their lack of success stem rather from existing structural elements of the healthcare system that could be reformed?
- Reference pricing and rewards programs have both been shown to be successful in bringing down costs. Why might this be and are those lessons applicable elsewhere?

Discussion Questions, continued

- Reference pricing financially penalizes consumers who spend more than the designated threshold. Rewards programs share financial savings with consumers when they choose lower-cost care. Which is the preferable approach?
- Narrow and tiered networks have both been shown to be effective at reigning in costs. However, consumers often bristle at being told which providers they can see and which they can't. Is it possible to get more consumers on board with these types of programs in order to decrease overall system costs?
- Shopping for health plans remains difficult given all the different components (e.g., premiums, deductibles, copayments, coinsurance, and out-of-pocket maximums). How might we make these products easier for consumers to understand and compare?
- In the future, do you think the US healthcare system will be more oriented towards consumer shopping, less oriented towards consumer shopping, or remain the same?

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