



## CONSUMER-DRIVEN MEDICAL CARE: TRANSPARENCY AND VALUE

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### **The Problem: High Spending, Average Return**

The cost of medical care in the United States has found a place on the political agenda because of expenditures that commonly escalate at rates far higher than inflation. The United States is the number one spender on health care, spending more than double what countries with similar economies spend per capita. The U.S. spent over \$5,283 per person in 2004,<sup>1</sup> with spending rates growing from 5-10% annually.<sup>2</sup> Even though the growth of spending has temporarily slowed,<sup>3</sup> health expenditures continue to take an increasing portion of both public and private resources, alerting many to the opportunity cost of a system left uncontrolled. Meanwhile, the U.S. ranks poorly on dimensions of access, safety, efficiency, and equity and has only average health outcomes.<sup>4</sup> The U.S. does not seem to be getting a return on its investment—value for its dollar. Blame has fallen on many sources, including the lack of adequate consumer-driven care supported by transparency of quality and cost.

### **Consumer-Driven Medical Care**

If the problem with increasing spending and costs is in part because of a lack of consumer-driven medical care, the solution is to develop it. The basic premise is that consumers are invested in the decisions surrounding their care. They have the incentive and ability to choose the care they deem most valuable and to take responsibility for the outcomes of their decisions. This inherently encourages accountability among providers and plans if they wish to compete for business. In the current system, care is becoming more consumer-driven. Consumers are responsible for a portion of the cost of their care, but they make decisions without clear information on quality and cost and without the incentive to use this information even if available. Still, health plans and employer contributions buffer individuals from most costs. Enrollees often pay the same amount for care regardless of the type of doctor seen, test performed or treatment received. Meanwhile, fee-for-service payment systems remain in place, reimbursing providers for volume rather than quality or efficiency.<sup>5</sup>

Attempts at consumer-driven care have resulted in giving greater control and risk to the consumer. Oftentimes, consumer-driven care manifests as the promotion of refundable tax credits or health savings accounts (HSAs). In the former, consumers would be given tax credits up to a given level in order to help them purchase insurance through their employers or in the individual market. President Bush proposed a refundable tax credit of \$7,500 per individual or \$15,000 per family in 2007.<sup>6</sup> Senator McCain proposed \$2,500 for individuals and \$5,000 for families, approximating the tax breaks for current employer contributions to premiums; in return, taxpayers would pay income taxes on the value of employer-paid benefits.<sup>7</sup> HSAs work by setting aside pre-tax dollars for out-of-pocket medical costs. An HSA is usually coupled with a high deductible health plan. With these plans, oftentimes premiums are low in return for a high deductible and/or an increased out-of-pocket maximum.<sup>8</sup> In this case, health insurance acts more like auto or homeowner's insurance; it steps in for catastrophic care, shifting risk to the individual for routine maintenance. Accordingly, high deductible health plans would seem to



require transparency, since the enrollee is completely responsible for the costs of care up to the deductible. Critics believe that HSAs leave people vulnerable to high out-of-pocket costs in the event that they seek care or are chronically ill, increasing the chance that they forego preventive care. In addition, HSAs are a regressive tax policy, producing the greatest savings for those in higher income tax brackets.<sup>9</sup> Supporters believe HSAs combined with high deductible health plans help with costs when care is absolutely necessary and beyond the amount of the deductible, preventing wasteful spending on routine care by assigning financial responsibility to the enrollee. Increasingly, plans define routine care to exclude preventive care and chronic disease management.<sup>10</sup> Supporters argue that the tax advantages that favor the wealthy are outweighed by the fact that HSAs are coupled with health plans that are cheaper than traditional plans. In addition, some legislation allows employers to give larger contributions to the savings accounts of their lower-income employees to offset the tax advantage.<sup>11</sup>

However consumer-driven care is implemented, the key is greater transparency.

### **Driving Value-Based Care Through Price and Quality Transparency**

In a market with greater transparency, a product or service would be expected to produce a given outcome for a given price, influenced by a payer's ability to pay for and desire to consume the product or service. This information would be organized and shared in a clear fashion, minimizing the need for a user to be trained in medicine. Payers would include a wide variety of consumers of care, including patients, public and private insurers, and employers; users could extend beyond these to include providers. Giving patients and other payers the ability to consider the cost and quality of care through transparency could help establish effective consumer-driven care; the desire to consider them would come naturally with the pursuit of one's self-interest in finding the best value.<sup>12</sup>

Sharing price information is a good starting point. Pricing is particularly useful if a patient is responsible for coinsurance, has not met his or her deductible, is uninsured and paying the list price, or is otherwise responsible for variations in price. It is less important for those in plans with flat cost sharing. Price information, however, can be ambiguous, as there are list prices, health plans' contracted prices and maximum allowable payments, on top of the actual cost of procedures—all of which may appear bundled or as single line items on claims.<sup>13</sup> In fact, hospital charges are often 2.5 times higher than actual costs, though providers rarely receive their charges as payment.<sup>14</sup> Further, price information cannot stand alone. It is most useful with information about what others are charging and what others are paying per procedure or visit, as well as the estimated total cost for treating a condition.<sup>15</sup> Quality information further assists with value-based purchasing.

### *Meaningful Data*

For both price and quality, there is the question of what is good data. Learning to collect, report and distribute meaningful data in a manner fair to providers and plans and clear to patients and other payers is a complicated task. We need to know what information payers need to make decisions about care and how best to approximate it with a measurement tool. A patient may want data on measures of performance involving effectiveness, patient safety, timeliness, patient centeredness, and equitable care.<sup>16</sup> For example, a patient may want to know a provider's comparative patient satisfaction ratings, clinical outcomes and error rates, experience and



education, or level of adherence to evidence-based treatment protocols. Others may want to know information relevant to choosing a health plan, such as customer service, claims processing ratings or reviews, medical loss ratios, or getting needed care including referrals to specialists.<sup>17</sup> Many efforts are being spearheaded by places like the Agency for Healthcare Research and Quality, the National Committee for Quality Assurance and the National Quality Forum. However, figuring out what to measure and how to measure it remains a challenge. If we measure everything that might be important, we could be wasting money and creating confusion. If we measure only a handful of things, we may miss key pieces or encourage providers to game the system—to attempt to improve only those things that are measured while neglecting equally important parts of care.<sup>18</sup> Further, comparing providers and plans effectively within an atmosphere of public trust requires the use of standardized, evidence-based measures shared through secure, interoperable health information technology.<sup>19</sup> Consensus on the content of and financing for a national, automated (routine) measurement system will be needed to maximize administrative simplicity.<sup>20,21</sup> Comparisons of providers and plans can be made on a smaller scale, such as at the state or local level, in order to ensure regional variations are factored into the analyses.<sup>22</sup>

Some posit translating health outcomes into dollars for the ease of comparing the cost effectiveness of treatment options. For example, a procedure may be worth an average of \$5,000 but cost \$7,500 at a given hospital or through a given health plan. Knowing this information, a purchaser may be inclined to look around for a better deal or consider the factors driving the cost difference, such as a low mortality rate or chance for a healthcare acquired infection. Making these factors more transparent and quantifiable is key, particularly since many people either do not equate high prices with high quality care or are not sure if there is a correlation.<sup>23</sup> Cost effectiveness arguments place return on investment before the value of life, placing a large burden of cost containment on costly sick patients. Care must be taken to guarantee cost effectiveness is not used to minimize the use of expensive but valuable services and does not have a harmful effect on patient health.<sup>24</sup>

Generating an accurate tool or unit of measurement will need to involve risk-adjustment. Certain patients are harder to treat and more at risk for complications, while certain facilities and providers treat and certain health plans insure more of the sick. The rate of success or failure in treating and responding to patients or enrollees needs must be weighted according to the intensity of the patients or enrollees served to minimize the incentive to avoid treating or insuring sick patients.

#### *Incentives: Cost Sharing and Pay-for-Performance*

Cost sharing has historically been used as an incentive to influence the consumption of health care products and services. The RAND Health Insurance Experiment showed its efficacy and its flaws. Current literature reinforces the same: increased cost sharing decreases utilization.<sup>25</sup> Patients are sensitive to cost—but at what cost? The goal of cost sharing should be to maximize favorable health outcomes while discouraging waste, but often utilization decreases regardless of value.<sup>26</sup> Even for the chronically ill who are likely to have higher volumes of care and overall spending, misuse can occur if cost sharing is too low or too high. Encouraging appropriate utilization is the proper goal.<sup>27</sup> A stronger link between quality and pricing must be made. To this



end, proper incentives for taking responsibility for one's medical care choices rely on adequate data.

To influence providers, pay-for-performance is being used and refined as a method to enhance accountability in the delivery of medical care. Commonly, this method aims to incentivize higher quality care by physician groups, because there is too much variability to measure outcomes at the level of the individual physician.<sup>28</sup> The basic premise is that providers will improve upon their services if given financial rewards for doing so, resulting in better health outcomes for patients. However, the motivation to improve depends upon several factors. These include the amount of the reward, reliable data on where providers currently stand and how much improvement is needed, and the ability to control the outcome. If a physician, provider group or facility in general is already meeting the standards of quality care, quality improvement will likely plateau. Or, if the financial reward (or penalty) itself is minor or not enforced, improvement may be minor if not nonexistent. An alternative to overcome this could involve tiered rewards and penalties,<sup>29</sup> or perhaps a moving average benchmark coupled with recognition of high performance. Similar to public reporting in general, pay-for-performance incentives without risk adjustment could motivate providers to avoid treating sick or difficult patients or otherwise game the system—within a culture that already suffers from underreporting of errors and near misses.<sup>30</sup>

With incentives to consider price and quality, the power of payers' abilities to choose the source of their care based on accurate and timely measures of value could encourage competition among insurers and providers. In essence, insurers and providers could measure themselves against the benchmark of their competitors. And, if consumer demand wields enough cumulative leverage to influence large insurer groups and consolidated hospital systems, private and public insurers would move to reward quality and efficiency and enhance their development, such as through pay-for-performance initiatives.<sup>31,32</sup> Price would have a stronger relationship to quality, delivering greater value.<sup>33</sup> This could additionally increase equity by improving the affordability of care for those with lower incomes.<sup>34</sup>

### Conclusion

Transparency and value-based medical care are in their early stages in the United States. Given enough resources and time, this country can move forward with efforts to contain costs through consumer empowerment. We can define and refine meaningful measures of quality and price and integrate them with supportive information technology. Using cost sharing and pay-for-performance, health care providers and plans can become more responsive to consumers. Even if transparency is not embedded in a purely free market, public awareness and individual responsibility can be heightened through data sharing, which is perhaps why transparency finds support on both sides of the aisle. President Bush issued an Executive Order in 2006 to promote transparency in price and quality for public programs, coupled with the adoption of health information technology.<sup>35</sup> Democratic California legislators have led the introduction of legislation directly or indirectly related to transparency.<sup>36</sup> Both red and blue states have proposed and enacted legislation that fosters transparency in recent years.<sup>37</sup> The clearer division of support lies in the friction between the different players in the health care system, with business, labor, and consumers often in support and physicians and hospitals in opposition. Some suggest that, rather than moving to public reporting of data prematurely, the development of transparency and



reporting of its outcomes should stay behind closed doors until perfected. They contend this would maintain the civil engagement of all stakeholders.<sup>38</sup> Even so, with greater and aggregated transparency in some form, we may continue to spend increasing portions of our budgets on medical care, but at least we will be getting greater value for our dollar.

<sup>1</sup> Centers for Medicare and Medicaid Services. (2007). Health expenditures by state of residence: state-specific tables, 1991-2004. Retrieved July 1, 2008 from <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/res-states.pdf>.

<sup>2</sup> Bodenheimer, T. (2005). High and rising health care costs. Part 1: seeking an explanation. *Annals of Internal Medicine*, 142(10): 847-854.

<sup>3</sup> The rate of growth slowed from 6.8% in 2005 to 6.6% in 2006. See: Ginsburg, P. (2008). Don't break out the champagne: continued slowing of health care spending growth unlikely to last. *Health Affairs*, 27(1): 30-32.

<sup>4</sup> Davis, K. et al. (2007). Mirror, mirror on the wall: an international update on the comparative performance of American health care. Retrieved July 1, 2008 from [http://www.commonwealthfund.org/usr\\_doc/1027\\_Davis\\_mirror\\_mirror\\_international\\_update\\_final.pdf?section=4039](http://www.commonwealthfund.org/usr_doc/1027_Davis_mirror_mirror_international_update_final.pdf?section=4039).

<sup>5</sup> Lee, P. and Hoo, E. (2006). Beyond consumer-driven health care: purchasers' expectations of all plans. *Health Affairs, Web Exclusive*: w544-w548.

<sup>6</sup> Mannanal, J. (2007). Evaluation of President Bush's healthcare plan. Retrieved July 14, 2008 from <http://www.itup.org/Reports/UniversalCoverage/Evaluation-Final.pdf>.

<sup>7</sup> FactCheck. (2008). McCain's \$5,000 promise. Retrieved July 14, 2008 from [http://www.factcheck.org/mccains\\_5000\\_promise.html](http://www.factcheck.org/mccains_5000_promise.html).

<sup>8</sup> The typical policy for a single individual has a \$2,400 deductible and \$3,400 out-of-pocket maximum, as compared to a typical PPO with a \$400 deductible and \$2,250 out-of-pocket maximum, although with premium costs about \$1,000 more expensive per year. To minimize this gap, the authors suggest revising HSA rules to raise contribution limits to out-of-pocket maximums, in addition to considering raising employer contributions for the chronically ill. See: Baicker, K., Dow, W. and Wolfson, J. (2008). Lowering the barriers to consumer-directed health care: responding to concerns. *Health Affairs*, 26(5): 1328-1332.

<sup>9</sup> Council of Economic Advisers. (2008). Economic report of the president. Retrieved July 14, 2008 from [http://origin.www.gpoaccess.gov/eop/2008/2008\\_erp.pdf](http://origin.www.gpoaccess.gov/eop/2008/2008_erp.pdf).

<sup>10</sup> Baicker, K., Dow, W. and Wolfson, J. (2008). Lowering the barriers to consumer-directed health care: responding to concerns. *Health Affairs*, 26(5): 1328-1332.

<sup>11</sup> The authors further argue that traditional plans' tax policies also favor high-income workers. See: Baicker, K., Dow, W. and Wolfson, J. (2008). Lowering the barriers to consumer-directed health care: responding to concerns. *Health Affairs*, 26(5): 1328-1332.

<sup>12</sup> Robinson, J. (2005). Managed consumerism in health care. *Health Affairs*, 24(6): 1478-1489.

<sup>13</sup> Shannon, D. (2008). Is health care ready for a full menu of prices? *Physician Executive*, 34(1).

<sup>14</sup> Private insurers often pay about 24% above cost. See: Colmers, J. (2007). Public reporting and transparency. Retrieved July 8, 2008 from [http://www.commonwealthfund.org/usr\\_doc/Colmers\\_pubreportingtransparency\\_988.pdf?section=4039](http://www.commonwealthfund.org/usr_doc/Colmers_pubreportingtransparency_988.pdf?section=4039).



- <sup>15</sup> Collins, S. and Davis, K. (2006). Transparency in health care: the time has come. Retrieved July 1, 2008 from [http://www.commonwealthfund.org/usr\\_doc/TransparencyTestimony\\_Collins\\_3-15-06.pdf?section=4039](http://www.commonwealthfund.org/usr_doc/TransparencyTestimony_Collins_3-15-06.pdf?section=4039).
- <sup>16</sup> Agency for Healthcare Research and Quality. (2007). National healthcare quality report 2007. Retrieved July 8, 2008 from <http://www.ahrq.gov/qual/nhqr07/nhqr07.pdf>.
- <sup>17</sup> Agency for Healthcare Research and Quality. (2007). What consumers say about the quality of their health plans and medical care. Retrieved July 8, 2008 from [https://www.caahps.ahrq.gov/content/NCBD/Chartbook/2007\\_CAHPS\\_HealthPlanChartbook.pdf](https://www.caahps.ahrq.gov/content/NCBD/Chartbook/2007_CAHPS_HealthPlanChartbook.pdf).
- <sup>18</sup> Snyder, L. and Newbauer, R. (). Pay-for-performance principles that promote patient-centered care: an ethics manifesto. *Annals of Internal Medicine*, 147(11): 792-794.
- <sup>19</sup> Azar, A. et al. (2007). Transparency in health care: what consumers need to know. Retrieved July 9, 2008 from [http://www.heritage.org/research/healthcare/upload/hl\\_986.pdf](http://www.heritage.org/research/healthcare/upload/hl_986.pdf).
- <sup>19</sup> Newhouse, J. Consumer-directed health plans and the RAND Health Insurance Experiment. (2004). *Health Affairs*, 23(6): 107-113.
- <sup>20</sup> O’Kane, M. et al. (2008). Crossroads in quality. *Health Affairs*, 27(3): 749-758.
- <sup>21</sup> It is important to note that the least trusted source for information on health care providers is government, and the most trusted is one’s doctor. See: Commonwealth Fund. (2005). EBRI/Commonwealth Fund consumerism in health care survey. Retrieved July 8, 2008 from [http://www.commonwealthfund.org/usr\\_doc/Consumerism\\_in\\_Health\\_Care\\_Toplines.pdf?section=4056](http://www.commonwealthfund.org/usr_doc/Consumerism_in_Health_Care_Toplines.pdf?section=4056).
- <sup>22</sup> Colmers, J. (2007). Public reporting and transparency. Retrieved July 8, 2008 from [http://www.commonwealthfund.org/usr\\_doc/Colmers\\_pubreportingtransparency\\_988.pdf?section=4039](http://www.commonwealthfund.org/usr_doc/Colmers_pubreportingtransparency_988.pdf?section=4039).
- <sup>23</sup> Commonwealth Fund. (2005). EBRI/Commonwealth Fund consumerism in health care survey. Retrieved July 8, 2008 from [http://www.commonwealthfund.org/usr\\_doc/Consumerism\\_in\\_Health\\_Care\\_Toplines.pdf?section=4056](http://www.commonwealthfund.org/usr_doc/Consumerism_in_Health_Care_Toplines.pdf?section=4056).
- <sup>24</sup> Braithwaite, R. and Rosen, A. (2007). Linking cost sharing to value: an unrivaled yet unrealized public health opportunity. *Annals of Internal Medicine*, 146(8): 602-605.
- <sup>25</sup> Newhouse, J. Consumer-directed health plans and the RAND Health Insurance Experiment. (2004). *Health Affairs*, 23(6): 107-113.
- <sup>26</sup> Braithwaite, R. and Rosen, A. (2007). Linking cost sharing to value: an unrivaled yet unrealized public health opportunity. *Annals of Internal Medicine*, 146(8): 602-605.
- <sup>27</sup> This may be the provision of subsidies, if the market cannot provide a range of products that are adequate and affordable to everyone.
- <sup>28</sup> Christianson, J., Knutson, D., and Mazze, R. (2006). Physician pay-for-performance. *Journal of General Internal Medicine*, S2(21): S9-S13.
- <sup>29</sup> Young, G. et al. (2007). Effects of paying physicians based on their relative performance for quality. *Journal of General Internal Medicine*, 22: 872-876.
- <sup>30</sup> Kohn, L., Corrigan, J., and Donaldson, M. (2000). To err is human: building a safer health system. Washington, D.C.: The National Academies Press.
- <sup>31</sup> Colmers, J. (2007). Public reporting and transparency. Retrieved July 8, 2008 from [http://www.commonwealthfund.org/usr\\_doc/Colmers\\_pubreportingtransparency\\_988.pdf?section=4039](http://www.commonwealthfund.org/usr_doc/Colmers_pubreportingtransparency_988.pdf?section=4039).
- <sup>32</sup> Azar, A. et al. (2007). Transparency in health care: what consumers need to know. Retrieved July 9, 2008 from [http://www.heritage.org/research/healthcare/upload/hl\\_986.pdf](http://www.heritage.org/research/healthcare/upload/hl_986.pdf).



<sup>33</sup> Collins, S. and Davis, K. (2006). Transparency in health care: the time has come. Retrieved July 1, 2008 from [http://www.commonwealthfund.org/usr\\_doc/TransparencyTestimony\\_Collins\\_3-15-06.pdf?section=4039](http://www.commonwealthfund.org/usr_doc/TransparencyTestimony_Collins_3-15-06.pdf?section=4039).

<sup>34</sup> Kyle, M. and Ridley, B. (2007). Would greater transparency and uniformity of health care prices benefit poor patients? *Health Affairs*, 26(5): 1384-1391.

<sup>35</sup> The White House. (2006). Executive Order: promoting quality and efficient health care in federal government administered or sponsored health care programs. Retrieved July 10, 2008 from <http://www.whitehouse.gov/news/releases/2006/08/20060822-2.html>.

<sup>36</sup> Currently in California, there are a few bills either directly or indirectly related to transparency. The leading bills include 1) AB 2967 (Lieber), which focuses on increasing cost and quality data reporting and quality improvement; 2) SB 158 (Florez) and SB 1058 (Alquist), both of which focus on greater transparency surrounding hospital-acquired infections (also called healthcare acquired infections or HAIs); and 3) SB 1300 (Corbett), which is intended to allow health plans to share data with their enrollees. These three authors are Democrats.

<sup>37</sup> National Conference of State Legislatures. (2008). Legislation relating to transparency and disclosure of health and hospital charges. Retrieved July 10, 2008 from <http://www.ncsl.org/programs/health/Transparency.htm>.

<sup>38</sup> Colmers, J. (2007). Public reporting and transparency. Retrieved July 8, 2008 from [http://www.commonwealthfund.org/usr\\_doc/Colmers\\_pubreportingtransparency\\_988.pdf?section=4039](http://www.commonwealthfund.org/usr_doc/Colmers_pubreportingtransparency_988.pdf?section=4039).