

ImproveHealthCare.org

## Consumerism in Health Care

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#### Disclaimer

All events described in this case are fictional and are designed to highlight real situations in medical practice. Any resemblance to any real-life cases is purely coincidental.

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# Consumerism in Health Care

## Case Summary

Involving the patient as a consumer of health care represents one strategy to control rising health care costs. This case follows a patient **diagnosed with breast cancer** as she navigates her way through the health care system as a “consumer” of health. The first and second vignettes focus on the best known example of consumer-oriented health care: consumer-directed health plans (CDHPs), which are characterized by high deductibles and health savings accounts (HSAs). These accounts are funded through employer and employee contributions and can help cover the deductible costs. Plans do not typically include copayment requirements, but may require coinsurance for out-of-network providers.

During the first vignette, we meet the patient and learn about her new CDHP. The discussion introduces the concept of consumer-directed health care and the structure and benefit design of CDHPs. The second vignette demonstrates the complex choices faced by consumers and illustrates the effects of CDHPs on health care utilization. The discussion digs deeper into the pros and cons of involving the patient as a consumer, the various influences on consumer choice, and the preliminary research on CDHPs (satisfaction, utilization, selection, etc.).

In the third and fourth vignettes, we switch gears to focus on the various ways that patients can become “empowered” to be better consumers of health care. The patient is first introduced to patient decision aids, tools designed to help patients choose services and procedures that they value highly. Finally, the patient tries to assimilate various information she finds on provider quality and cost. The discussion addresses the history of public reporting and the potential benefits of having informed consumers who choose high-quality and cost-efficient care.

## Part I

You are a primary care physician at an academic medical center. Your 42-year-old female patient presents with a three-day history of dysuria. Through the course of her visit, you learn that her husband recently got a new job, and their family's new health insurance is a consumer-directed health plan (CDHP). You now have several patients enrolled in this type of plan, and you're curious about her benefit design and experiences thus far. "We picked this plan because it has the lowest premium and my husband and I are pretty healthy. I'm a little hazy on the details," she says, "but I know we have a really high deductible—\$10,000 for the family. We have to pay for a portion of some services, but nothing for others. We also have a health savings account set up through his employer—they contribute \$800 each year—so some of our costs can be covered through that account. I don't know; it's all confusing."

Your patient is otherwise quite healthy, and as such, her interview and physical exam were generally unremarkable:

### CC

Dysuria

### PMH

Major illness, injuries, hospitalizations: Ø

Allergies: PCN

Reproductive Hx: G2P2

Cigarettes, EtOH, Drug Use: Ø

### Family Hx

Paternal history of type 2 DM. Pertinent negatives include cancer, depression, and cardiovascular disease.

### Vitals

Temperature: 98.6°F; RR: 15; Pulse: 70; BP: 120/80

### ROS

Unremarkable

### PE

Unremarkable

Urinalysis reveals grossly cloudy urine and a positive dipstick result, suggestive of an uncomplicated urinary tract infection. According to guidelines, you prescribe a three-day course of Bactrim. Given her age, you also recommend that she go for her first mammogram; before that, however, you indicate that there is some controversy about the correct age to start screening.

## Discussion Questions

What is the rationale behind a benefit design such as your patient's plan, as outlined in Appendix 1?

According to this plan, if a nonspecialist visit typically costs around \$70 and a urinalysis \$25 (see Appendix 2 for cost information), what would your patient pay for the current visit to your office, assuming she has not yet reached the deductible, she still has available funds in

her HSA, and you are a nonspecialist provider in her network? What would she pay if her HSA were depleted but she had not yet reached the deductible?

Would you expect your interactions with patients enrolled in this type of plan to differ from interactions with patients enrolled in more traditional managed care plans? If so, how?

## **Discussion: The Nuts and Bolts of Consumer-Directed Health Plans**

### *Introduction to consumer-directed health care*

This case vignette introduces the concept of consumer-directed health care, one of the ways through which patients today are encouraged to be prudent consumers of health care. Consumer-directed health care is one proposed solution to soaring health care costs. CDHPs combine high-deductible coverage with tax-advantaged HSAs, effectively shifting the responsibility for health care spending to the patient until catastrophic coverage takes over. In an era of constrained resources and rising costs, proponents of this benefit design hope that patients will become more active, “value-conscious purchasers.”<sup>1</sup>

Despite the novelty and limited uptake of CDHPs, they present immediate challenges and ethical dilemmas for physicians. By empowering patients to weigh the risks and make cost-conscious decisions regarding health care utilization, CDHPs have the potential to radically shift the role of the physician when decisions that affect patient spending are on the line. Additionally, the physician may face the ethical dilemma of providing different “levels” of care based on patients’ health insurance status, financial constraints, and corresponding willingness to pay for certain services.<sup>2</sup> As CDHPs mature and spread, these issues may play out in a variety of ways.

### *How CDHPs work*

The first CDHPs were established in the late 1990s by a few small insurers. Reports of cost savings attracted interest among an alliance of conservatives and insurers, who lobbied Congress to place consumer-directed health care on the political agenda. The Medicare Modernization Act of 2003 then permitted employers and insurers to establish HSAs for beneficiaries enrolled in high-deductible plans. CDHPs currently represent about 5% of employer-sponsored health plan enrollment.<sup>3</sup>

Exact benefit design may vary, but CDHPs share two characteristics:

- 1) *A high deductible, up to which the consumer is responsible for all costs in a given year.* After the consumer reaches this threshold, the plan covers further costs, typically with coinsurance. In 2008, federal regulations required that for contributions to an HSA to be tax exempt, the deductible must be at least \$1,100 for individuals and \$2,200 for families.

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<sup>1</sup> Bloche MG. Consumer-directed health care. *N Engl J Med.* 2006 Oct 26;355(17):1756-9.

<sup>2</sup> *Ibid.*

<sup>3</sup> Kaiser Family Foundation. “How Private Health Insurance Works: A Primer, 2008 Update.” April 2008. Publication #7766. <http://www.kff.org/insurance/upload/7766.pdf>

- 2) *A personal health account that contains funds to cover health care costs.* The two primary types of these accounts are health savings accounts (HSAs) and health reimbursement accounts (HRAs). HSAs are tax-advantaged personal savings accounts that are set up by the consumer. Both employers and employees can contribute to the account, up to an annual limit. Funds may be used to pay for the costs of care up to the deductible. The funds in the HSA are portable (i.e., are retained by the employee if he/she switches employers or loses his/her job) and flexible (i.e., they roll over from year to year). HRAs also contain tax-advantaged funds that can be used to pay for medical expenses, but unlike HSAs, health reimbursement accounts are funded solely by employers. While unused funds may roll over year to year, HRAs lack the portability of HSAs—employees may not retain the funds should they leave the employer. In 2008, contributions to HSAs were capped at \$2,900 for self-coverage and \$5,800 for family coverage.<sup>4,5,6</sup>

As an example, in the case vignette described above, the patient would be responsible for the expenses of the office visit (estimated \$95). Assuming her HSA is replete and that she is below the deductible, she would be able to cover the expenses fully through HSA funds.

The figure below also illustrates the principles of the benefit design through a comparison of health care spending in a CDHP and a typical preferred provider organization (PPO). The example compares a \$2,000 deductible CDHP with a \$500 deductible/\$1,000 out-of-pocket maximum PPO plan. Note that in the CDHP example below, as in the in-network plan detailed in Appendix 1, neither coinsurance nor copayments are required from the beneficiary (with the exception of preventive health services). In fact, copayments are typically not required of CDHP enrollees, except for certain preventive care services. For these preventive services, the patient would pay only the copayment, and the difference between the charge for the service and the copayment would not be deducted from the patient's health account. CDHPs may, however, choose to require coinsurance after the deductible, up to the out-of-pocket maximum set by the Internal Revenue Service (\$5,600 for individuals and \$11,200 for families in 2008).<sup>7</sup>

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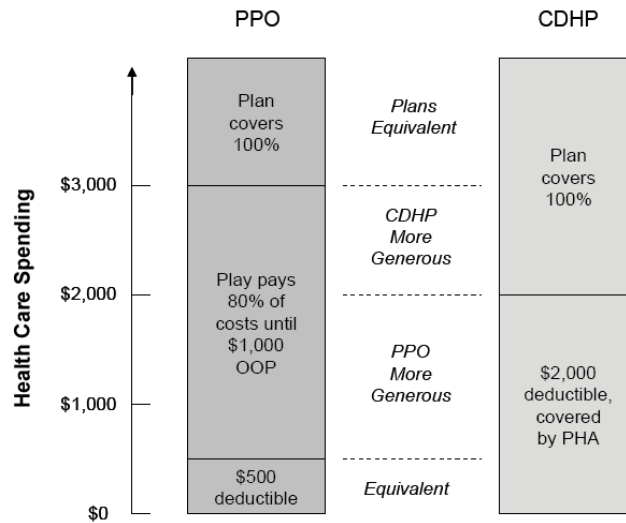
<sup>4</sup> Kaiser Family Foundation. "National Survey of Enrollees in Consumer Directed Health Plans." November 2006. Publication #7594. <http://www.kff.org/kaiserpolls/upload/7594.pdf>

<sup>5</sup> Baker L, et al. Consumer-Oriented Strategies for Improving Health Benefit Design: An Overview. Technical Review 15 (Prepared by the Stanford University–UCSF Evidence-based Practice Center, Stanford, CA under Contract No. 290-02-0017.) AHRQ Publication No. 07-0067. Rockville, MD: Agency for Healthcare Research and Quality. July 2007.

<http://www.ahrq.gov/downloads/pub/evidence/pdf/consumer/consorient.pdf>

<sup>6</sup> United States Department of the Treasury. HSA Basics. <http://www.ustreas.gov/offices/public-affairs/hsa/pdf/HSA-Tri-fold-english-07.pdf>

<sup>7</sup> *Ibid*



Source: AHRQ, <http://www.ahrq.gov/downloads/pub/evidence/pdf/consumer/consorient.pdf>

#### *Variations on benefit design*

Another component of consumer-oriented benefits is tiered provider networks, at both the hospital and the provider levels. Tiered network design is an additional attempt to encourage consumers to consider costs in their health care choices. As with tiered drug formularies, which require different cost-sharing levels for generic drugs, preferred brand drugs, and nonpreferred brand drugs, this design assigns hospitals and/or providers to different cost-sharing tiers, with the plans' preferred providers requiring the lowest copayments. Assignment to tiers can be based on a number of criteria, including cost-effectiveness and quality indicators.

Several challenges exist with this type of design. The effectiveness of such financial incentives on hospital and/or provider utilization is largely unknown. Many patients may place a very high value on factors such as distance or physician and family recommendations and therefore might not be influenced by modest copay differences. In addition, the effective integration of quality-of-care indicators into the network design is challenged by the lack of reliable comparative data. Some argue that hospital tiering may introduce social-equity issues, as lower-quality hospitals may frequently fall in the lower-cost range, leaving higher-quality care accessible only for those who can afford it.<sup>8</sup> One recent study of a large national insurer demonstrates that these potential inequalities have not yet come to pass, with minority beneficiaries evenly distributed across the performance network.<sup>9</sup> Finally, with

<sup>8</sup> Mays GP, Claxton, G, and BC Strunk, Tiered Provider Networks: Patients Face Cost-Choice Trade-Offs. Center for Studying Health Systems Change, Issue Brief #71, November 2003 [www.hschange.org/CONTENT/627/627.pdf](http://www.hschange.org/CONTENT/627/627.pdf)

<sup>9</sup> Brennan TA, et al. Do managed care plans' tiered networks lead to inequalities in care for minority patients? *Health Aff (Millwood)*. 2008 Jul-Aug;27(4):1160-6.

its focus on provider choice (not resource choice, per se), provider tiering may be limited in its ability to prevent inappropriate usage of health care resources.<sup>10 11</sup>

The figure below outlines another benefit design that incorporates both tiers and networks and demonstrates the cost differences felt by patients (i.e., differences in patient out-of-pocket costs). Keep in mind that a specialist consult can cost nearly \$200, while an MRI is more than \$2,000 (see Appendix 2 for estimated costs). If a patient is under the deductible and sees an in-network provider, the cost he or she pays can differ by \$10 or \$20, depending on the tier of the provider. Though relatively small, these costs can add up. More dramatic differences appear if the patient chooses between an in-network and an out-of-network provider. For the out-of-network provider, the patient is responsible for the cost up to the deductible, plus 20% of the cost after the deductible is met. This could mean a difference of \$185 for a specialist visit (\$15 for an in-network Tier 1 provider vs. \$200 for an out-of-network provider), or \$2,000 for an MRI (\$0 vs. \$2,000, assuming the patient has not yet met the deductible). These numbers demonstrate the real costs felt by consumers when choosing their providers.<sup>12</sup>

Outpatient Medical Care	In-Network (Covered in full after applicable copay)	Out-of-Network (After deductible)
Primary Care Physician office visits	\$15 per visit	Plan covers 80%
Specialist office visits	Tier 1: ★★★ Excellent—\$15 per visit Tier 2: ★★ Good—\$25 per visit Tier 3: ★ Standard—\$35 per visit All other specialists: \$25 per visit	Plan covers 80%
Routine Physical Exams (One physical per calendar year)	\$15 per visit	Plan covers 80%
Well-Child Care	\$15 per visit	Plan covers 80%
OB/GYN Care	Tier 1: ★★★ Excellent—\$15 per visit Tier 2: ★★ Good—\$25 per visit Tier 3: ★ Standard—\$35 per visit	Plan covers 80%
Maternity Care	Covered in Full	Plan covers 80%
Diagnostic Imaging, Lab Tests, Pap Smears, Mammograms	Covered in Full	Plan covers 80%
Diagnostic Screening Procedures - Procedure Only	Covered in Full	Plan covers 80%
Diagnostic Screening Procedures - Procedure with Treatment/Surgery	\$100	Plan covers 80%
Speech Therapy	Covered in Full	Plan covers 80%
Short-Term Physical and Occupational Therapy	\$15 per visit	Plan covers 80%
Routine Eye Exams (One exam per 24 months)	\$15 per visit	Plan covers 80%
Spinal Manipulation (Up to 20 visits per calendar year)	\$15 per visit	Plan covers 80%

Source: Navigator by Tufts Health Plan Benefit Summary, <http://www.tuftshealthplan.com/GIC/PDF/GIC%20Benefit%20Summary%20FINAL.pdf>

The last major design component that aims to shift responsibility for health care costs to the consumer is the use of medical management programs. Instead of managing physician behaviors through strategies such as prior authorizations or primary care gatekeeping, as plans have done in the past, CDHPs have implemented management programs that target patient behaviors (e.g., diet and exercise, medication compliance). The intensity of the program varies by condition and severity and also by purchasers' willingness to pay for health care quality and disease- prevention interventions. On one end of the spectrum, plans target consumers through mail and Internet-based disease-prevention reminders. For

<sup>10</sup> Robinson JC. Hospital Tiers in health Insurance: Balancing Consumer Choice with Financial Motives. Health Aff (Millwood). 2003 Jan-Jun;Suppl Web Exclusives:W3-135-

46. <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w3.135>

<sup>11</sup> Baker, et al. (2007).

<sup>12</sup> Mercy Health Plans. Procedure Pricing. <http://www.mercyhealthplans.com/savvyshopper/cost/>

patients with more complex and chronic conditions, however, nurse managers speak with patients by telephone to track their self-assessed health measures, to provide information, and to coordinate various physician visits and care.<sup>13</sup>

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<sup>13</sup> Robinson JC. Reinvention of Health Insurance in the Consumer Era. *JAMA*. 291, no. 15 (2004): 1880–1886.

## Part II

Your patient returns one year later, after finding a lump in her breast during a routine self-exam. She is very upset and confesses that she had foregone the mammogram last year because her husband had been in a car accident and had tapped out their HSA with his emergency room and physical therapy costs. They had been experiencing financial troubles and did not feel they could afford the extra costs of the mammogram. “With all the different tiers and copays, I wasn’t sure what I had to pay. Besides,” she says, “no one in my family has ever had breast cancer. I figured a year wouldn’t hurt.” Still confused by the costs she faces with the mammogram, she hands you the details of her health plan (see Appendix 1). You scan to check the cost of a mammogram, which for her is included under preventive services. The cost of the mammogram would not apply toward her deductible and instead would require a \$25 copay.

You convince her to go for a mammogram, and the results are suggestive of cancer. After diagnostic mammogram and core needle biopsy by a radiologist, the pathologist determines that the lesion is ductal carcinoma in situ (DCIS):

BREAST (LEFT), EXCISION:

- 1) DUCTAL CARCINOMA IN-SITU, SEE TABLE #1.
- 2) HEALING BIOPSY SITE.
- 3) MULTIPLE LEVELS EXAMINED.

TABLE OF PATHOLOGICAL FINDINGS #1  
DUCTAL CARCINOMA IN-SITU

TUMOR SIZE: Involving 19 of 23 blocks and estimated to span at least 4.5 cm.

GRADE: 2 to focal 3.

CALCIFICATIONS: Present in the ductal carcinoma in-situ and focally in benign changes.

MARGIN OF DUCTAL CARCINOMA IN-SITU: Positive at the medial, superior, posterior, and anterior margins of the specimen.

STAINS FOR RECEPTORS: Requested on block E2.

You need to refer her to an oncologist. The one to whom you always refer your patients—an outstanding clinician—is out of network for her plan, meaning she would pay 50% of the cost per visit even after the deductible is met. You have another clinician in mind, one who happens to be in her network, but you are less confident with that referral. You present her with your opinion and ask her what she would like to do.

### Discussion Questions

- Under the CDHP benefit design, what factors might influence consumer choice?
  - What effect do you think CDHPs will have on the utilization of services? Preventive health services? Unnecessary health services?
  - How might individual incentives vary with the level of funds in the HSA? If the individual is close to reaching the deductible?
- Are patients equipped to make decisions about which health care services to use?
  - Are some patient populations better “consumers” than others?
  - What information do patients need to make good choices?
- Some argue that CDHPs will attract younger and healthier patients—like the patient seen in this case. How might this influence the overall insurance market?

## Discussion: Beyond the Nuts and Bolts... How Do CDHPs Perform?

### *Both sides of the coin*

The consumer-directed health care movement has fueled a powerful debate regarding the ability of patients to be prudent consumers of health care. Proponents of CDHPs argue that consumer-oriented designs will teach patients to be better health care consumers. Specifically, it is claimed that by shifting the responsibility to consumers, the plans will foster cost-consciousness in health care consumption and will thus lead to decreased costs.<sup>14,15</sup>

The skeptics, on the other hand, argue that CDHPs are a thinly veiled excuse for shifting costs from employers to employees. Opponents believe that consumers will undervalue important services such as chronic care management, or will delay seeking care, leading to poor outcomes.<sup>16</sup> Others worry that preventive services will be underutilized.<sup>17</sup> Most CDHPs waive the costs of preventive services, and thus cost should theoretically not factor into decisions about preventive services. Research on prescription-drug cost sharing, however, has shown that patients' adherence to treatment is inversely proportional to the degree of complexity of the cost-sharing structure.<sup>18</sup> In other words, complex benefit design may lead to decreased adherence. Indeed, a Kaiser Family Foundation survey of CDHP enrollees determined that only 64% of enrollees found their plan easy to understand (compared with 79% for enrollees in traditional insurance).<sup>19</sup> If these principles from prescription-drug cost sharing carry over to CDHPs, the complexity of tiers, networks, and cost-sharing structures may have implications for utilization of important services.

Other skeptics point out that CDHPs will destabilize traditional risk pooling and will lead to adverse selection. Because of the high degree of cost-sharing, the elderly and chronically ill populations may face higher costs under CDHPs. The plans may therefore attract only the young and healthy, which could lead to an increase in premiums for those who remain in traditional insurance (as premiums reflect the illness profiles of the plan members and the actuarial costs).<sup>20,21,22</sup> In addition, opponents argue that CDHPs are unaffordable for many

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<sup>14</sup> Herzlinger RE. Consumer-Driven Health Care: Taming the Health Care Cost Monster. *Journal of Financial Service Professionals* 8, no. 2 (2004): 44–48.

<sup>15</sup> Miller T. Getting on the soapbox: views of an innovator in consumer-directed care. *Health Aff (Millwood)*. 2006 Nov-Dec;25(6):w549-51.

<sup>16</sup> Bloche (2006).

<sup>17</sup> The U.S. Preventive Services Taskforce makes recommendations based on age and sex for preventive services according to a review of the evidence and an estimation of the magnitude of benefit (e.g., mammograms are recommended every 1-2 years for women over age 40); U.S. Preventive Services Task Force. *The Guide to Clinical Preventive Services 2007*. <http://www.ahrq.gov/clinic/pocketgd07/pocketgd07.pdf>

<sup>18</sup> Reed M, et al. Coping with prescription drug cost sharing: knowledge, adherence, and financial burden. *Health Serv Res*. 2008 Apr;43(2):785-97.

<sup>19</sup> KFF.org #7594.

<sup>20</sup> *Ibid*.

<sup>21</sup> McNeill D. Do Consumer-Directed Health Benefits Favor the Young and Healthy? *Health Aff (Millwood)*, 2004 Jan-Feb;23(1):186-93.

<sup>22</sup> Robinson JC. Renewed emphasis on consumer cost sharing in health insurance benefit design. *Health Aff (Millwood)* (2002) Jul-Dec;Suppl Web Exclusives:W139-54. <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w2.139>

low-income families and may exacerbate already problematic access issues. Particularly sensitive to cost-sharing, any low-income families enrolled in CDHPs may be more likely to forgo preventive services.<sup>23</sup>

Finally, the lack of good-quality information and decision-support tools is a major drawback to CDHPs. Experts argue that the decision-support tools provided by insurance plans are inadequate to help consumers assess the cost and quality of medical services. For example, insurance carriers might provide information on hospital quality, but might fail to provide the corresponding information at the physician level. Similarly, consumers might have access to average cost data, but would not have the information on actual costs for their physician. Skeptics argue that consumers cannot make the important cost-conscious decisions without all of the facts.<sup>24,25</sup>

#### *Influences on consumer choice*

Theory and early evidence suggest that many factors, including price and access to care and information, may interact to influence a patient's health care choice and thus health care spending and outcomes.

The price of services is an obvious influence on consumer choice, and motivating cost-conscious consumers is the main impetus behind the consumer-oriented movement. Tiered hospital and provider networks aim to influence consumer choice by varying the out-of-pocket costs faced by the consumer depending on the cost and quality rating of the hospital or provider. Consumers may be more or less responsive to price changes depending on whether their health condition is symptomatic, as well as the severity of the need (e.g., preventive services may be “price-elastic,” while acute services may be more “price-inelastic”).<sup>26</sup>

Consumer choice may also be influenced by the restrictions placed through provider networks and tier structures. The degree of restriction may range from a very limited choice of providers to extensive networks (in an example of the latter, Tufts Health Plan Advantage PPO allows consumers to choose from more than 20,000 physicians and 85 hospitals).<sup>27</sup> As is the case with pricing, consumers may be more or less responsive to provider restrictions. Patients with longstanding relationships with their physicians may be less inclined to switch to a network provider. Market characteristics, such as the number and structure of physicians and hospitals in the area, may also influence the degree of patient responsiveness. Finally, readily available and clearly presented information on health care costs and quality can influence patient choice, especially for sicker patients who stand to benefit more immediately from the care they receive.<sup>28</sup>

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<sup>23</sup> Hoffman C and Tolbert J. “Health Savings Accounts and High Deductible Health Plans: Are They An Option for Low-Income Families?” For the Kaiser Commission on Medicaid and the Uninsured. October 2006. Publication #7568. <http://www.kff.org/uninsured/upload/7568.pdf>

<sup>24</sup> Bloche (2006).

<sup>25</sup> GAO. “Consumer Directed Health Plans.” <http://www.gao.gov/new.items/d06514.pdf>

<sup>26</sup> Baker, et al. (2007).

<sup>27</sup> “Tufts Health Plan Advantage PPO with HRA.” [http://www.tuftshealthplan.com/pdf/APPO\\_HRA\\_1107.pdf](http://www.tuftshealthplan.com/pdf/APPO_HRA_1107.pdf)

<sup>28</sup> Baker, et al. (2007).

*Evidence on CHDP enrollment, experience, and resource utilization*

Evidence is beginning to emerge on the experience with and effects of CDHPs. Overall, researchers have demonstrated favorable risk selection, mixed evidence on satisfaction, and mixed evidence on the effects of CDHPs on utilization and outcomes. A review of preliminary evidence has also demonstrated modest decreases in health care spending.<sup>29</sup>

One study suggests that enrollees in CDHPs tend to have higher incomes and better health status than their counterparts in more traditional insurance plans (characterized by lower deductibles and no HSAs).<sup>30</sup> For example, a 2007 Employee Benefit Research Institute/Commonwealth Fund survey of 4,217 privately insured adults aged 21 to 64 found that those enrolled in a CDHP had significantly higher incomes, had achieved higher levels of education, and enjoyed better self-rated health status than those enrolled in more comprehensive health plans.<sup>31</sup> Similarly, a survey of 272 adults by the Kaiser Family Foundation found that enrollees in CDHPs were more likely to be white (88% vs. 72%), college graduates (57% vs. 35%), wealthier (45% vs. 30% have an income of \$75,000 or greater), and in excellent or very good health (64% vs. 52%), and were less likely to have a chronic condition (23% vs. 35%) than the control population (enrollees in non-CDHP employer-sponsored insurance).<sup>32</sup> Finally, a longitudinal survey of employees at a manufacturing company compared the experience of employees enrolled in two versions of a CDHP (high and low deductible) with the experience of those enrolled in traditional health plans and found similar patterns of selection between the CDHP and PPO.<sup>33</sup>

Studies examining enrollee satisfaction provide mixed results. The Employee Benefit Research Institute/Commonwealth Fund survey found that enrollees in CDHPs were significantly less satisfied with their out-of-pocket costs (24% vs. 46% were extremely or very satisfied) and their insurance plans overall (47% vs. 64%) than were those having comprehensive coverage with. The survey found that enrollees in CDHPs would be less likely to recommend the plan to a friend (39% vs. 52% were extremely or very likely to recommend) or stay in the current plan if given the choice (49% vs. 64%).<sup>34</sup> However, another study of 14 CDHPs found an annual renewal rate of 90% and corresponding survey results reporting relatively high satisfaction.<sup>35</sup>

Evidence on cost and quality information suggests that CDHPs may not provide adequate information. The same study of 14 CDHPs found that only half provided any kind of decision support, and the information provided was limited and imprecise.<sup>36</sup> Despite limited information, there is evidence to suggest that enrollees in CDHPs are better consumers of

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<sup>29</sup> Buntin MB, et al. "Consumer-directed health care: early evidence about effects on cost and quality." *Health Aff (Millwood)*. 2006 Nov-Dec;25(6):w516-30.

<sup>30</sup> *Ibid.*

<sup>31</sup> Fronstin P and Collins SR. Findings From the 2007 EBRI/Commonwealth Fund Consumerism in Health Survey (March 2008). EBRI Issue Brief, No. 315, March 2008

[http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=1113488#PaperDownload](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1113488#PaperDownload)

<sup>32</sup> KFF.org #7594.

<sup>33</sup> Dixon A, Greene J, Hibbard J. Do Consumer-Directed Health Plans Drive Change in Enrollees' Health Care Behavior? *Health Aff (Millwood)*. 2008 Jul-Aug;27(4):1111-1119.

<sup>34</sup> Fronstin and Collins (2007).

<sup>35</sup> Rosenthal M, Hsuan C, Milstein A. A report card on the freshman class of consumer-directed health plans. *Health Aff (Millwood)*. 2005 Nov-Dec;24(6):1592-600.

<sup>36</sup> Rosenthal, et al. (2005).

information on hospital and provider cost and quality than their counterparts in more traditional insurance plans. One study showed that CDHPs enrollees were generally more likely to seek health and cost information than their counterparts in the PPO arrangement. For example, 3.9% in the lower deductible plan sought information on hospital quality, while only 1.0% of enrollees in the PPO accessed such information.<sup>37</sup> Similarly, the EBRI/ Commonwealth Fund survey found that CDHP enrollees were more likely than those in comprehensive coverage to seek information on hospital and provider cost/quality (34% vs. 18% and 25% vs. 17% respectively). They also appeared to be better consumers of the information. CDHP enrollees were more likely to check whether the health plan would cover care (60% vs. 50%), to ask for cheaper prescription drug alternatives (38% vs. 30%), and to check the price of services before getting care (27% vs. 21%).<sup>38</sup> The Kaiser Family Foundation survey yielded similar results, with enrollees in CDHPs more likely to ask for and choose lower cost options than those in traditional insurance plans.<sup>39</sup>

Because previous studies have shown that use of medically appropriate health care services decreases with increases in cost sharing, many have been interested to study the effects of CDHPs on the utilization of preventive and other necessary care.<sup>40 41</sup> Thus far, the research has been mixed, with evidence to suggest that use of preventive services has been maintained but that enrollees may forego or delay other necessary care. Several studies have demonstrated that rates of preventive service use were maintained after the introduction of CDHPs. Importantly, these plans provided full coverage and eliminated the cost-sharing requirements for these preventive services (e.g., cancer screening, lipid screening, and diabetes care).<sup>42,43</sup> The EBRI/ Commonwealth Fund survey similarly found no significant overall change in medical service use or preventive care use between groups. However, among adults with chronic conditions, enrollees in CDHPs were significantly less likely than those in other types of plans to follow their regimens for arthritis and hypertension (61% vs. 43% and 91% vs. 81%, respectively) and were more likely to delay or avoid health care due to cost (29% vs. 16%).<sup>44</sup> A study of employees at a large manufacturing company found that enrollees in CDHPs were more likely to forego both necessary and unnecessary care, and this observation held for both acute and chronic care.<sup>45</sup> Similarly, another study found that enrollees in CDHPs were more likely to engage in risky cost-saving behavior than their PPO counterparts. These high deductible enrollees were significantly more likely than those in the PPO plan to forego an appointment (6.5% vs. 1.9%), to delay or decide against treatment or surgery (3.8% vs. 1.4%), or to not fill a prescription (4.3% vs. 1.6%), furthering the argument

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<sup>37</sup> Dixon, et al. (2008).

<sup>38</sup> Fronstin and Collins (2007).

<sup>39</sup> KFF.org #7594.

<sup>40</sup> Rice T, Matsuoka KY. The impact of cost-sharing on appropriate utilization and health status: a review of the literature on seniors. *Med Care Res Rev.* 2004;61(4):415–52.

<sup>41</sup> Lohr, KN, et al. Brook, R. H., Kamberg, C. J., Goldberg, G. A., Leibowitz, A., Keesey, J., Reboussin, D., & Newhouse, J. P. Use of medical care in the Rand Health Insurance Experiment. *Diagnosis and service-specific analyses in a randomized controlled trial. Medical Care, 1986. 24, S1-87.*

<sup>42</sup> Busch SH, et al. Effects of a cost-sharing exemption on use of preventive services at one large employer. *Health Aff (Millwood).* 2006 Nov-Dec;25(6):1529-36.

<sup>43</sup> Rowe, JW, et al. “The effect of consumer-directed health plans on the use of preventive and chronic illness services.” *Health Aff (Millwood).* 2008 Jan-Feb;27(1):113-20.

<sup>44</sup> Fronstin and Collins (2007).

<sup>45</sup> Hibbard JH, et al. Does Enrollment in a CDHP Stimulate Cost-Effective Utilization? *Med Care Res Rev.* 2008 Apr 10.

that CDHP enrollees are unable to distinguish between necessary and unnecessary care.<sup>46</sup> The Kaiser Family Foundation survey revealed similar results, with CDHP enrollees more likely than traditional insurance enrollees to not fill a prescription, to forego needed care, and to skip a test of treatment due to cost.<sup>47</sup> Another study looking specifically at prescription drug use found that enrollees in CDHPs were significantly more likely than their PPO counterparts to discontinue the use of anti-hypertensives and lipid-lowering drugs.<sup>48</sup>

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<sup>46</sup> Dixon, et al. (2008).

<sup>47</sup> KFF.org #7594.

<sup>48</sup> Greene J, et al. The Impact of Consumer-Directed Health Plans on Prescription Drug Use. Health Aff (Millwood). 2008 Jul-Aug;27(4):1120-1131.

### Part III

Your patient decides to see the oncologist who is in her network, citing cost as the major reason. After speaking with the pathologist and oncologist, you learn that she requires resection and possibly radiation therapy. The specialists tell you that cases like hers are controversial. There are no clear cut answers (breast-conserving surgery vs. mastectomy), making the treatment decisions complex.

Your patient schedules a follow-up appointment with you to discuss her results and treatment options. You are not surprised by this visit, since many of your past breast cancer patients have had difficulty deciding between the mastectomy and the breast-conserving surgery (BCS) and have come to you for help in the decision-making process. You enjoy helping your patients with these tough decisions and find that they often highly value your opinion. You remember hearing about a new patient “decision aid” that your colleagues have been using to help their patients make difficult decisions. You decide to pull up the tool on your computer and take a look:

Breast-conserving surgery (lumpectomy or partial mastectomy) for breast cancer: <http://www.peacehealth.org/kbase/topic/detail/surgical/zt1573/detail.htm#zt1579>  
Information form to help prepare for surgery: <http://www.peacehealth.org/kbase/topic/detail/surgical/zt1580/detail.htm>

Print this form and fill in the information if your doctor recommends that you have a surgical procedure.

General questions	
What is the name of the surgical procedure?	
Why do I need surgery?	
How soon should surgery take place?	
What might happen if I delay or avoid the surgery?	
What results should I expect from the surgery?	
Are there any nonsurgical options?	<input type="radio"/> Yes <input type="radio"/> No
If yes, describe:	
Are there any less invasive surgery options?	
What is the next step if this surgery doesn't work?	
How much does the surgery cost? How can I find out?	

You are impressed by how well the documents walk the reader through what to expect, what to think about, what questions to ask, and the effectiveness and risks associated with the procedures. You decide to prescribe the tool to your patient. You tell her that she should take a look at it before she comes in for her appointment, and that the two of you will walk through the decision together during her visit.

### Discussion Questions

- In contrast to “effective” treatments, which are deemed to have benefits that outweigh the risks for all patients with certain clinical characteristics, optimal choices for “preference sensitive” treatments depend upon how an individual patient weighs the benefits vs. harms.
  - Do you consider these “preference sensitive” decisions to be another form of “consumer-oriented” care?
  - Why is patient-centered care an important aspect of high quality care?
- Decision aids are thought to improve decision quality and prevent the overuse of treatments that patients do not value.
  - How would you define decision quality?
  - Are decision aids a good idea? Do you expect them to change the role of physicians in patient counseling? How will you guide your patients to make decisions using these tools?

### Discussion: Helping the Consumer Choose

#### *Patient-centeredness and the movement toward shared decision-making*

Many consider patient-centeredness and shared decision-making to be another form of consumer-oriented care. As in this case, many medical decisions exist in a gray zone, in which considerable discretion exists, and the best choice thus depends on how patients value the benefits and harms. Examples of such decisions include the choice for hormone replacement therapy for menopause, treatment for early cancer, surgery for benign prostatic hypertrophy, and end-of-life care.<sup>49</sup> Researchers in the 1980s recognized the importance of involving patient preferences in these health care decisions. As Sepucha, et al. writes, “Failure to take account of such warranted variation among patients renders health care decision making impersonal, as interventions are provided to people who would not choose them and withheld from those who would.”<sup>50</sup>

In response, shared decision-making—that is, decision-making that involves both the patient and the physician—has gained ground in recent years. Supporting this movement, the Institute of Medicine has recognized patient-centeredness as an essential component of high-quality care. Without patient involvement, care is impersonal, unresponsive to

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<sup>49</sup> O'Connor AM. Using decision aids to help patients navigate the "grey zone" of medical decision-making. CMAJ. 2007 May 22;176(11):1597-8

<sup>50</sup> Sepucha KR, Fowler FJ, and Mulley AG. Policy Support for Patient-Centered Care: The Need for Measurable Improvements in Decision Quality. 2004;Suppl Web Exclusives:VAR54-62 <http://content.healthaffairs.org.ezp-prod1.hul.harvard.edu/cgi/reprint/hlthaff.var.54v1>

individual needs, and inefficient.<sup>51</sup> Patient decision aids—informational documents that complement professional counseling and aim to “explain options, clarify personal values for the benefits versus harms, and guide patients in deliberation and communication”—have evolved to assist patients in the decision-making process.<sup>52</sup> The goal of these aids is to decrease the use of services that patients do not value and increase decision quality, that is “the extent to which [a decision] reflects the considered needs, values, and expressed preferences of a well-informed patient and is thus implemented.”<sup>53</sup> Decision aids:

- provide facts about the condition, options, outcomes, and probabilities;
- clarify patients’ evaluations of the outcomes that matter most to them; and
- guide patients in the steps of deliberation and communication so they can make a choice that matches their informed values.<sup>54</sup>

#### *Decision support today*

The support for patient decision aids (PtDAs) has grown over the past decade. Libraries of decision aids are growing, and the International Patient Decision Aid Standards Collaboration (IPDAS) has evolved to develop quality criteria for decision aids. Decision aids themselves may involve call centers or may be integrated into clinical practice.<sup>55</sup> The format of PtDAs ranges from videos to Internet resources to pamphlets.<sup>56</sup>

PtDAs are also under review to test for efficacy. A recent meta-analysis reviewed 55 randomized control trials (RCTs) that tested 51 different PtDAs focused on 23 different treatment areas. Among many others, these treatment decisions included breast cancer surgery, hormone replacement therapy initiation, prenatal diagnostic screening for Down syndrome, and PSA testing. The review found that PtDAs improved decision quality and led patients to feel more informed and clear about personal values.<sup>57</sup> Despite growth of infrastructure and support for shared decision-making and PtDAs, as well as research supporting the efficacy of the model, it has yet to be widely accepted and practiced.<sup>58</sup>

#### *Decision support for breast cancer treatment*

Results of several RCTs have demonstrated equivalent outcomes for breast-conserving surgery and mastectomy for early-stage breast cancer, and as such, the National Cancer Institute supports BCS as the preferred option.<sup>59</sup> Variations in BCS rates still exist, however, raising questions about the extent of patient involvement and provoking an interest in PtDAs. A recent systematic review of RCTs of decision-aid use among women with early-

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<sup>51</sup> Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the Twenty-first Century* (Washington: National Academies Press, 2001).

<sup>52</sup> O’Connor AM, et al. Do Patient Decision Aids Meet Effectiveness Criteria of the International Patient Decision Aid Standards Collaboration? A Systematic Review and Meta-analysis. *Medical Decision Making*, Vol. 27, No. 5, 554-574 (2007)

<sup>53</sup> Sepucha, et al. (2004)

<sup>54</sup> O’Connor, et al. Toward the “tipping point”: decision aids and informed patient choice. *Health Aff (Millwood)*. 2007 May-Jun;26(3):716-25.

<sup>55</sup> *Ibid*

<sup>56</sup> O’Connor, et al. (*Medical Decision Making*, 2007)

<sup>57</sup> *Ibid*

<sup>58</sup> O’Connor, et al. (*Health Affairs*, 2007)

<sup>59</sup> NIH Consensus Conference: Treatment of early-stage breast cancer. *JAMA* 265:391-395, 1991

stage breast cancer found that women who used the decision aid were 25% more likely to choose BCS. The decision aids also led to increased patient knowledge and satisfaction. The decision aids ranged from paper aids to audiotape to computer-based aids. All involved weighing the risks and benefits of BCS vs. mastectomy. Most were carried out in the office setting but did not directly involve the physician.<sup>60</sup>

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<sup>60</sup> Waljee JF, Rogers MA, Alderman AK. Decision aids and breast cancer: do they influence choice for surgery and knowledge of treatment options? *J Clin Oncol.* 2007 Mar 20;25(9):1067-73.

## Part IV

After using the decision-making tool and discussing her options with you, your patient decides to have BCS and radiation. As soon as you begin to discuss referrals for her surgery, she digs into her purse. “A friend of mine had her breast cancer surgery at Faulkner Hospital and highly recommended it. I’ve also been looking online for information, because I wanted to have some basis for comparing my choices. I’m not sure what to do because the information online makes it look like the Brigham and Mass General have better surgical care, but my friend spoke so highly of her experience. The patient-satisfaction data look mixed. I’m not sure what to make of the data from the Leapfrog Group. Take a look,” she says as she hands you a few pieces of paper that she printed off the Internet.

### Surgical Care Improvement/Surgical Infection Prevention (from Medicare.gov—Hospital Compare <http://www.hospitalcompare.hhs.gov>)

Hospital Process of Care Measure	Percentage for BWH	Percentage for MGH	Percentage for Faulkner
Percent of surgery patients who received preventive antibiotic(s) one hour before incision, if appropriate*	89% of 417 patients	95% of 483 patients	94% of 298 patients
Percent of surgery patients who received the appropriate preventive antibiotic(s) for their surgery, if appropriate*	96% of 427 patients	97% of 493 patients	93% of 303 patients
Percent of surgery patients whose preventive antibiotic(s) are stopped within 24 hours after surgery, if appropriate*	87% of 396 patients	88% of 457 patients	87% of 291 patients
Percent of surgery patients whose doctors ordered treatments to prevent blood clots (venous thromboembolism) for certain types of surgeries, if appropriate*	95% of 129 patients	98% of 180 patients	95% of 149 patients
Percent of surgery patients who received treatment to prevent blood clots within 24 hours before or after selected surgeries if appropriate*	95% of 129 patients	97% of 180 patients	95% of 148 patients
Survey of Patients’ Hospital Experience	Percentage for BWH	Percentage for MGH	Percentage for Faulkner
Percent of patients who reported that their doctors “Always” communicated well	81%	77%	82%
Percent of patients who reported that they “Always” received help as soon as they wanted	65%	57%	59%
Percent of patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)	76%	77%	64%
Percent of patients who reported “Yes,” they would definitely recommend the hospital	83%	85%	69%

\* The percentage includes only patients whose history and condition indicate the treatment is appropriate.

**Leapfrog Hospital Ratings (<http://www.leapfroggroup.org>)**

Hospital	Leap 1	Leap 2	Leap 3								Leap 4	Transparency Indicator	Adherence to Never Events+ Policies
	CPOE	ICU	CABG	PCI	AAA	Esophagectomy	Panc. Resection	Bariatric	Aortic Valves	NICU			
Faulkner												+	
BWH												+	
MGH												+	

- Fully implemented Leapfrog's recommended quality and safety leap
  - Good progress in implementing Leapfrog's recommended quality and safety leap
  - Good early-stage effort in implementing Leapfrog's recommended quality and safety leap
  - Willing to report publicly; did not yet meet Leapfrog's criteria for a good early-stage effort
  - Not applicable; e.g., pancreatic resection does not apply because hospital does not perform pancreatic resections
- + "Never events" are those that should never be seen in hospitalized patients. CMS publishes a list of these yearly.

**Discussion Questions**

- Patients can now visit any number of consumer-directed websites to learn about provider cost and quality and patient satisfaction. Two popular examples that compare hospital performance include Medicare's Hospital Compare website (<http://www.hospitalcompare.hhs.gov>) and the Leapfrog Group's website (<http://www.leapfroggroup.org>). According to the Medicare website, publicly available information on quality "not only helps you make good decisions about your health care, but also encourages hospitals to improve the quality of health care they provide." Do you agree? Why do you think so many consumer-quality websites make information on hospital cost and quality publicly available?
- Do you think patients use the information that is publicly available to them appropriately? If you were a patient, would you use this information? How, if at all, should physicians help their patients navigate the myriad sources of information?

**Discussion: Educating the Consumer through Quality and Cost Information**

*The growth of publicly available information*

The growth in recent years of publicly available information on hospital and provider quality represents another attempt to include consumers in decisions that involve health care costs and quality. The consumer population is among several target audiences, which also include employers, health plans, providers, and policymakers. The purpose of public reporting is not only to provide consumers with information to make decisions regarding cost and quality,

but also to stimulate improvements in health care by providing feedback and comparative data for providers. A brief history of the development of public reporting, together with a few examples of the websites available to consumers, illustrates the vast array of available information.

Interest in collecting and reporting cost and quality information began in 1984, when the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services, or CMS) began reporting hospital mortality rates for Medicare patients. In the early 1990s, states began reporting hospital and surgeon-specific mortality rates for open-heart surgery, and the National Committee for Quality Assurance (NCQA) began reporting data on performance of and satisfaction with health plans. In 2002, the National Quality Forum launched an initiative to measure and report data on serious, preventable adverse events.<sup>61</sup> A wide range of health care providers, from hospitals to physicians to health plans, report information to various organizations today. Reported information ranges from volume information to medical errors to consumer satisfaction to adherence to recommended preventive care.<sup>62</sup>

Consumers can now visit any number of websites to gather information on provider performance. For example, Medicare's Hospital Compare website allows consumers to view Process of Care measures (i.e., how frequently the hospitals adhere to evidence-based guidelines), Hospital Outcomes of Care measures (i.e., 30-day mortality rates), results from a survey on patient experiences, and payment and volume information for given services. The website represents a collaboration between CMS and the Hospital Quality Alliance (a public-private collaboration dedicated to improving hospital care). According to the website, "This information helps you, your health care provider, family, and friends compare the quality of care provided in the hospitals that agree to submit data on the quality of certain services they provide for certain conditions. This quality information not only helps you make good decisions about your health care, but also encourages hospitals to improve the quality of health care they provide."<sup>63</sup> (See <http://www.hospitalcompare.hhs.gov>.)

The Leapfrog Group was founded by several large employers and is now a "growing consortium of major companies and other large private and public healthcare purchasers."<sup>64</sup> Its mission is to support informed decision-making and promote high-value health care. The "leaps" displayed when a consumer compares hospitals signify the hospitals' progress on the National Quality Forum-endorsed 30 Safe Practices. The first three leaps (adoption of computer physician order entry, evidence-based hospital referral based on results of certain high-risk surgeries, and intensive care unit [ICU] staffing by physicians experienced in critical care medicine) represent three of the Safe Practices, and the Leapfrog Safe Practices Score (Leap 4) is a summary statistic of the hospitals' progress on the remaining 27 practices. (See <http://www.leapfroggroup.org>.)

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<sup>61</sup> Colmers JM. Public Reporting and Transparency. The Commonwealth Fund, February 2007. [http://www.commonwealthfund.org/usr\\_doc/Colmers\\_publicreportingtransparency\\_988.pdf?section=4039](http://www.commonwealthfund.org/usr_doc/Colmers_publicreportingtransparency_988.pdf?section=4039)

<sup>62</sup> Colmers (2007)

<sup>63</sup> United States Department of Health and Human Services. "Hospital Compare—Hospital Quality Overview." <http://www.hospitalcompare.hhs.gov/Hospital/Static/About-Overview.asp?dest=NAV|Home|About|Overview#TabTop>

<sup>64</sup> The Leapfrog Group. "About Us: Factsheet." [http://www.leapfroggroup.org/about\\_us/leapfrog-factsheet](http://www.leapfroggroup.org/about_us/leapfrog-factsheet)

In Massachusetts, another source of information for the consumer is the Health Care Quality and Cost Council. It disseminates information on health insurance, hospital cost and quality, and provider cost and quality with the mission “to develop and coordinate the implementation of health care quality improvement goals that are intended to lower or contain the growth in health care costs while improving the quality of care, including reductions in racial and ethnic health disparities.”<sup>65</sup> For example, a consumer interested in finding cost and quality information related to a specific procedure (e.g., hip fracture) would be able to access a report with mortality and cost information by hospital name for all hospitals in Massachusetts. The website also provides links to the Medicare Hospital Compare tool, the Leapfrog Group website, and the Joint Commission on the Accreditation of Healthcare Organizations website.

(See <http://www.mass.gov/?pageID=hqcchomepage&L=1&L0=Home&sid=Ihqcc>.)

Finally, the Agency for Healthcare Research and Quality provides a searchable compilation of various health care “report cards” dating from the mid-1990s. The purpose of this Health Care Report Card Compendium is “to help consumers and patients better understand and choose among their health plan or provider options.”

(See <http://www.talkingquality.gov/compendium/index.html>.)

#### *Evidence on public reporting*

If public reporting of information is intended to successfully drive improvements in health care quality, then the measures must accurately correlate with clinical outcomes and the reporting must stimulate improvements in quality. In addition, the successful empowerment of consumers to make choices regarding their health care requires that information be accurate, useful, and accessible.

Some of the reported measures directly capture clinical outcomes, and research shows that other non-outcome-related performance measures correlate well with clinical outcomes. For example, results from a study on the effectiveness of the Leapfrog Group suggest that Leapfrog scores may indeed correlate with better process scores and improved mortality rates, as evidenced by superior 30-day mortality scores for acute myocardial infarction and pneumonia.<sup>66</sup> Another study evaluating the accuracy of Medicare’s Hospital Compare tool found that hospital-performance measures correlate with risk-adjusted mortality rates.<sup>67</sup>

Research has also supported the argument that public reporting can improve quality by providing feedback and comparison. One study that compared publicly available patient-satisfaction data with ongoing hospital quality-improvement efforts showed that the reported data reinforced and enhanced existing quality-improvement efforts.<sup>68</sup> Another

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<sup>65</sup> Mass.gov. Healthcare Quality and Cost Council. [http://www.mass.gov/?pageID=hqcutilities&L=1&sid=Ihqcc&U=Ihqcc\\_welcome](http://www.mass.gov/?pageID=hqcutilities&L=1&sid=Ihqcc&U=Ihqcc_welcome)

<sup>66</sup> Jha AK, et al. Does the Leapfrog group help identify high quality hospitals? *Jt Comm J Qual Patient Saf.* 2008 Jun;34(6):318-25.

<sup>67</sup> Wenrner RM and Bralow ET. Relationship between Medicare’s hospital compare performance measures and mortality rates. *JAMA.* 2006 Dec 13;296(22):2694-702

<sup>68</sup> Barr JK, et al. Using Public Reports of Patient Satisfaction for Hospital Quality Improvement. *Health Services Research,* June 2006 41(3 Pt. 1):663–82.

study demonstrated that public reporting stimulated quality-improvement efforts in widespread areas needing improvement.<sup>69</sup>

Despite these promising findings, a few broad challenges exist. In reality, the ability of consumers to obtain good information is limited. There is currently no standard or clearinghouse to ensure the quality of publicly reported information, so consumers have no way to ensure the quality of the information they find. In addition, in order for health care quality information to be sound, the measures must be accurate and reproducible and must also capture clinically important data. The websites that report accurate and reproducible measures might not be the same websites that appeal to consumers as being the most clinically relevant (e.g., the information from CMS in the case above may be sound but may not provide clinically relevant information to the patient choosing her surgery). A gap exists between what consumers of health care want and what the current state of quality measurement can offer.<sup>70</sup>

In addition to these general considerations, research has highlighted more specific limitations to the success of public reporting as a tool for quality improvement and consumer empowerment. For example, the way in which information is presented—with different visual cues, orders, trend data, and/or summary data—can have a significant impact on the way the data are interpreted and understood.<sup>71</sup> Another study summarizing the research in the field found that publicly reported data have only had a minimal impact on patient decision-making, with anecdotal evidence and friendly recommendations carrying more weight.<sup>72</sup> In addition, research has suggested that one reason for limited uptake and use of the information is a lack of consumer understanding.<sup>73</sup> Finally, consumers must believe that quality is a problem that can be improved in order for comparative cost and quality information to be useful.<sup>74</sup>

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<sup>69</sup> Hibbard JH, Stockard J, and Tusler M. Does Publicizing Hospital Performance Stimulate Quality Improvement Efforts? *Health Aff (Millwood)*. 2003 Mar-Apr;22(2):84–94.

<sup>70</sup> Mort, Elizabeth, M.D., M.P.H. (Vice President, Quality and Safety, Associate Chief Medical Officer, MGH). Personal Interview. 12 September 2008.

<sup>71</sup> Hibbard JH, et al. Strategies for reporting health plan performance information to consumers: evidence from controlled studies. *Health Serv Res*. 2002 Apr;37(2):291-313.

<sup>72</sup> Marshall MN, et al. The Public Release of Performance Data: What Do We Expect to Gain? A Review of the Literature. *JAMA*. Apr. 12, 2000 283(14):1866–74.

<sup>73</sup> Hibbard JH, Jewett JJ, Engelmann S, Tusler M. Can Medicare beneficiaries make informed choices? *Health Aff (Millwood)*. 1998;17:181-193.

<sup>74</sup> Shaller D, et al. Consumers and Quality-Driven Health Care: A Call to Action. *Health Aff (Millwood)*. 2003 Mar-Apr;22(2):95-101.

## **Part V**

Your patient decides to have her BCS and radiation therapy at the Brigham. The surgery is a success, and she expresses to you that she is very happy with her decisions—both the decision to have BCS and her choice of hospital. She remains cancer-free and is now diligent about her yearly mammograms.

### **Discussion Questions**

In what ways was the patient in this case involved as a “consumer” in her care?

Do you think that consumer-oriented care will prove to be an effective tool for cost control and quality promotion?

- How do you think CDHPs will affect health care utilization in the aggregate?
- How do you think patient decision aids will influence health care utilization?
- How do you think publicly available information will influence health care utilization, cost, and quality?

### **Conclusion**

Using a case study of a patient diagnosed with breast cancer, this discussion focused on the changing role of the consumer in the health care system, including:

- new health insurance benefit designs that attempt to engage consumers in making health care more efficient
- changes in the information available for patients to make informed decisions regarding providers and treatment options
- implications of new consumer-driven health care products and the role of the physician in consumerism

As discussed throughout the case, involving the patient as a consumer of health care represents one strategy to control rising health care costs. By confronting patients with the costs of office visits and procedures, by giving them the tools necessary to make informed decisions, and by providing them with information on provider quality and cost, proponents of consumer-oriented health care hope to make patients more prudent consumers. On the other hand, many argue that patients are not equipped to make difficult decisions regarding health care utilization and that when costs are shifted to them, they will underutilize important and necessary health care services. The consumer-directed health care movement is still in its infancy, but early evidence is emerging. For example, research suggests that CDHPs create conditions of adverse selection and may destabilize insurance risk pooling. In the public reporting arena, some research has suggested that public reporting motivates improvements in cost and quality, yet many patients continue to give more weight to anecdotal evidence and friendly recommendations. Only time and further investigation will determine whether consumer-directed health care strategies are successful.

## Appendix 1

Member Benefits	In Network	Out of Network
Deductible	\$5,000 individual/\$10,000 family	\$10,000 individual/\$20,000 family
Coinsurance	0% after deductible	50% after deductible
Coinsurance maximum	\$0 individual/\$0 family	\$2,500 individual/\$5,000 family
Out-of-pocket maximum	\$5,000 individual/\$10,000 family	\$12,500 individual/\$25,000 family
Lifetime maximum	\$5,000,000	\$5,000,000
Nonspecialist office visit	0% after deductible	50% after deductible
Specialist Visit	0% after deductible	50% after deductible
Hospital admission	0% after deductible	50% after deductible
Outpatient surgery	0% after deductible	50% after deductible
Urgent care	0% after deductible	50% after deductible
Emergency room	0% after deductible	0% after deductible
Maternity	Not covered (except for preg. complications)	Not covered (except for preg. complications)
Preventive health	\$25 copay*; deductible waived (insurance company will pay \$200 maximum)	50% after deductible (insurance company will pay \$200 maximum)
Lab/X-ray	0% after deductible	50% after deductible
Skilled nursing	0% after deductible (30 days per cal. yr.**)	50% after deductible (30 days per cal. yr.**)
Physical/Occupational therapy	0% after deductible (\$25 max. per visit/24 visits per cal. yr.)	50% after deductible (\$25 max. per visit/24 visit per cal. yr.)
Home health care	0% after deductible (30 visits per cal. yr.**)	50% after deductible (30 visits per cal. yr.**)
Durable medical equipment	0% after deductible (insurance company will pay up to \$2,000 per cal. yr.**)	50% after deductible (insurance company will pay up to \$2,000 per cal. yr.**)

\* Copay is billed separately and is not due at time of service. Copay does not count toward coinsurance or out-of-pocket max. Copays are not due for other services.

\*\* Maximum applies to combined in- and out-of-network benefits.

Source: Aetna quote finder, high-deductible HSA compatible plan (<https://www.aetna.com/iqs/aimquote.do>).

## Appendix 2

<b>Service</b>	<b>Average Cost*</b>
Routine office visit	\$70
Specialty consult	\$185
Urinalysis	\$25
CAT Scan	\$1,300
MRI	\$2,300
Mammography	\$175
CABG	\$67,600
Cardiac catheterization	\$10,700
Emergency room	\$1,000

\*Costs estimates are based on procedure pricing for Mercy Health Plans (St. Louis, Mo.) and likely underestimate average national costs.

Source: Mercy Health Plan, Procedure Pricing (<http://www.mercyhealthplans.com/savvyshopper/cost/>)

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