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Helping Consumers Make High-Value Health Care Choices: the Devil Is in the Details

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With the continued growth of cost-sharing in private health insurance plans (Claxton et al. 2016; Cohen, Martinez, and Zammitti 2016) and proliferation of reports about the costs and quality of health care (Kullgren, Duey, and Werner 2013; James 2012), many Americans now routinely face a dizzying array of complex choices about where to receive their health care. Beyond the impact of these choices on the health and pocketbooks of individual consumers, there is hope that reporting of quality and costs can steer consumers to providers and facilities that generate the best health outcomes for the resources utilized. If many consumers use these reports in this way, this could potentially improve the overall value of health care spending.

In theory, this task of steering consumers to high-value providers and facilities appears straightforward. Consumers increasingly have incentives to choose high-value providers, measurement and reporting of quality and costs to consumers continues to advance (Findlay 2016), and providers and facilities are increasingly being rewarded for providing high-value care (Joynt Maddox et al. 2017). In practice, however, steering consumers to high-value providers has proven difficult. There are a number of reasons why. First, many Americans' choices about where to receive health care services are influenced more by the recommendations of family and friends (Tu and Lauer 2008) or their health plan's network (Haeder, Weimer, and Mukamel 2015) than information about quality or cost (DiJulio, Firth, and Brodie 2015; Scanlon et al. 2015). Second, even when individuals attempt to use reports of quality or cost, the information in these reports may be primarily intended to influence providers (Mehrotra et al. 2012) and thus may have limited utility for consumers. Third, even when public reports are intended for consumers, the information they contain is often incomplete (Kullgren, Duey, and Werner 2013; Kullgren et al. 2017) and therefore may not be helpful in their decisions. Consequently, there is little evidence that public reporting of performance data has impacted choices of health care consumers in a meaningful way (Ketelaar et al. 2011).

The Power of Measures That Are Simple and Familiar

In their paper, "Presenting Cost and Efficiency Measures That Support Consumers To Make High-Value Health Care Choices," Greene and Sacks confronted these challenges in three experiments that examined how different ways of providing information about costs and quality influenced consumers' hypothetical choice of hospitals and interest in cost information. In each experiment, the authors wisely used a mix of measures from existing public reports and alternative measures with promise for better consumer understanding and facilitation of high-value choices.

Across these experiments, several important insights emerged. Describing a hospital in terms of its median cost of care in dollars or using the label "affordable" increased the percentage of consumers who chose the higher-value hospital. Characterizing readmission rates using the words "below," "average," or "better" led to quicker choices that favored the higher-value hospital. After viewing quality information, consumers were more interested in viewing

information about the per-visit out-of-pocket (OOP) costs of providers than other types of information about providers' costs. Altogether, simpler information presentations that may have been more familiar to consumers were more likely to produce higher-value choices.

Interestingly, consumers in an HDHP were no more likely than consumers in a traditional plan to use cost or quality information to make a high-value choice, and were only slightly more interested in knowing the average annual total costs of diabetes care for physicians. These findings suggest that reports of quality or cost may be insufficient alone to help consumers who face high cost sharing optimize the value of their OOP spending.

Just as important as the authors' findings about what worked to encourage high-value choices are their findings about what did not work well. Presenting cost information as the CMS spending ratio both increased the time to choose a hospital -- indicating increased cognitive processing time and perhaps confusion with the measure -- and decreased the proportion of consumers who chose the higher-value hospital. When an indicator for being a "high quality, affordable" hospital was used, it led to less cognitive processing but was no more likely to facilitate choosing the higher-value hospital. For information on readmissions, all presentations of rates (i.e., raw rates, raw rates plus additional explanations, or the inverse of the rates) were inferior to a simple word icon. For different types of costs, consumers were less interested in presentations of annual costs or the total costs to the consumer and health plan. Greene and Sacks did not design the three experiments to explore why such measures were less effective, and future research should seek to understand at a granular level why certain measures are less likely to yield high-value choices. These results and those of previous studies (Kurtzman and Greene 2016) send a clear message to designers of reports for consumers that different ways of labeling providers, even if well-intentioned and reasonable, may not lead more consumers to choose those with lower cost and better quality.

Examining How Different Types of Information Impact Actual Consumer Choices

One important limitation of these experiments that Greene and Sacks acknowledge is that participants were making hypothetical choices. It is possible that when consumers face actual binding health care decisions, their reactions to information about quality and cost could differ. Thus there is a need to examine how different information presentations influence real world

decisions. One way this could be accomplished would be to embed A/B testing in quality and price comparison tools provided by health plans or third party vendors. With this strategy, actual consumer choices could be compared for different randomly assigned information presentations. Another opportunity would be to engage consumers who are ready to make a decision about a provider or hospital (e.g., new health plan enrollees who need to choose a primary care provider or consumers whose provider orders a procedure that they could receive from multiple different places). A mixed methods approach would allow future researchers not only to examine how different information presentations influence consumer choice, but also to explore what consumers perceive about these different presentations.

Leveraging Cost and Quality Reports to Encourage High-Value Consumer Choices

So what do these findings mean for the future of reporting quality and costs to consumers? Some may view with pessimism the findings that seemingly small changes in presentation of information can sway consumer choice of a hospital, concluding that such unfamiliar, complex, and high stakes decisions should be largely taken out of the hands of consumers. From this view, a better investment of resources and attention may be limiting choice to networks of high-value providers, or using trained navigators to guide consumers to a high-value provider. Yet the constraints of limited networks may not be broadly acceptable to the American public (Blendon et al. 1998), and the resources required to extend navigators to routine health care decisions may not be sustainable.

A more optimistic view is that the current generation of quality and cost reports may be insufficient to produce high-value consumer choices without concomitant new strategies and supports. Fortunately, there are promising ways in which cost and quality reports could be enhanced or complemented to facilitate high-value consumer decisions. First, reports could leverage market research by online retail companies to provide comparative information on costs and consumer experience through a customizable interface that provides recommendations tailored to a consumer's characteristics and past choices. Notwithstanding the obvious differences between health care services and consumer products available for purchase through online marketplaces, public reports that incorporate these familiar design principles could enhance consumer engagement and understanding. Second, recent innovations in insurance

benefit design layer financial incentives onto quality and cost information. For example, tiered provider networks, in which there are lower copayments for providers with higher levels of cost-efficiency, could lead more consumers to choose higher-value providers (Sinaiko and Rosenthal 2014). Reference pricing, in which an employer limits what they will pay for a service, can shift volume from higher-price facilities to lower-price facilities (Robinson and Brown 2013). Both benefit designs report information to consumers and preserve a broad choice of providers, but supplement this foundation with financial incentives to encourage high-value choices. Finally, though public reports of quality and cost have now been in place for years (Scanlon et al. 2015; Mittler et al. 2013; Kullgren, Duey, and Werner 2013), using this information to choose where and from whom to receive health care likely remains unfamiliar, if not outright daunting, to many consumers. Thus, an untapped opportunity is to help consumers learn how to use quality and price information in their interactions with the health care system (Kullgren 2015). This strategy would approach consumerism as a teachable health behavior, and could be particularly helpful for consumers with ongoing medical needs who face high cost sharing. When paired with the enhancements to cost and quality reporting suggested by the findings of Greene and Sacks, these policy innovations have great potential to realize the promise of improving consumer choices to enhance the value of population health care spending.

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