The Faulty Logic of "Consumerism" in Health Care

We can't "shop" our way out of the health care crisis

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It's not uncommon to hear the refrain that too many people get too much care, expensive or otherwise, for trivial or the wrong reasons. Or, more to the point, because they don't have high deductibles to stop them.

When we fail to rationally control health care prices, eliminate medical profiteering, or take effective measures to reduce unnecessary health treatments, fraud, and high administrative costs, we find ourselves focused on how to change personal behavior to reduce medical utilization in order to bring down costs.

In other words, by refusing to look under the cost-and-quality hood of the health care system, we focus by default, and often place blame, on workers and their families.

High-Deductible Health Plans: Rationing by Income Class

The pointed emphasis on "consumerism" and reduced utilization with high-deductible health plans amounts fundamentally to rationing by income, though nobody in the insurance world describes it that way. The rationing imperative is disguised or softened in the language of "consumer empowerment," "risk assessment," "freedom," and "choice."

It's Still the Prices

Spending increases in health care are largely due to the escalating **price of services**, not increases in utilization.

Niall Brennan, president of the Health Care Cost Institute (HCCI), said recently, "It's time to have a national conversation on the role prices pay in the growth of health care spending. **Despite the progress made in recent years on value-based care, the reality is that working Americans are using less care but paying more for it each year."**[1]

HCCI released a study in January based on an analysis of about 4 billion claims incurred by 40 million individuals up to age 65 with employer-sponsored insurance. The data came from four

[1] http://www.healthcostinstitute.org/wp-content/uploads/2018/01/2016-Report-News-Release-1-16-18v2-1.pdf

of the largest private insurers in the country and represents the medical expenses of roughly 26 percent of Americans insured by their employers.

Here is a sample of the report's findings for the period 2012-16:

Inpatient Care

Utilization: Decreased 12.9 percent
Spending: Increased 8.3 percent (The average inpatient admission price increased by 24.3 percent.)

Surgical Admissions

Utilization: Decreased 16 percent
Spending: Increased 9.2 percent. (The price of the average facility fee for the average surgical admission rose by $10,000 to $41,702.)

Outpatient Services

Utilization: Decreased 0.5 percent
Spending: Increased 17.1% (The price per unit increased 17.7 percent.)

Professional Services

Utilization: Decreased 2.9 percent
Spending: Increased 11.2 percent (The average price per service increased 14.6 percent.)

Emergency Room Services

Utilization: Increased 1.8 percent
Spending: Increased 33.9 percent. (The average price of an ER visit increased by 31.5 percent.)

Prescription Drugs

Utilization: Increased by 1.8 percent
Spending: Increased 27.2 percent (Brand-name drugs saw a cumulative growth in average price, as measured in "allowed amounts," of 110 percent.)[2]

[2] https://www.healthaffairs.org/do/10.1377/hblog20180208.27999/full/

Profiteering & Market Failure

The findings of HCCI are backed up by earlier research from the **International Federation of Health Plans.**

Tom Sackville, the federation's chief executive, commented as follows on a large body of cross-national, health-care data the federation published in 2013:

"First, it gives the lie to the idea that some countries spend more on health as a result of higher utilization. ***It is all about unit price,…."*** *Second, we have looked here at a number of procedures and products which are* ***identical across the markets surveyed****. The price variations bear no relation to health outcomes: they merely demonstrate* ***the relative ability of providers to profiteer at the expense of patients****, and in some cases reflect a damaging degree of market failure"*[3]

Consumers Union: Consumers have little control over their healthcare spending

Consumers Union (CU), the advocacy arm of Consumer's Report, in a 2017 fact sheet, wrote:

"High-deductible health plans are promoted as a tool to contain healthcare costs. Yet, HDHPs as a solution ignores the fact that ***consumers have little control*** *over their healthcare spending. Further, HDHPs fail to address* ***marketplace failures*** *as they do not* ***motivate providers to lower their prices or practice medicine more efficiently****.*[4]

Cost & Quality Transparency: A lot of room for improvement

Altarum's Center for Payment Innovation and the organization Catalyst for Payment Reform jointly released state report cards for 2017 on health care price transparency and physician quality transparency. The results are extremely depressing, and should give "skin-in-the-game" adherents pause.

Vermont received a "C" on cost transparency and an "F" on quality transparency.

Close to home, **New Hampshire** got an "A" on cost transparency and an "F" on quality transparency. **Massachusetts** got an "F" and "D," respectively. **New York** was given an "F" in both categories, as were 36 other states.[5]

According to a national survey released in 2016 by the **Kaiser Family Foundation and the New York Times,** "Seven in ten (69 percent) of those who shopped around for a lower price on

[3] www.ifhp.com/1404121

[4] http://consumersunion.org/wp-content/uploads/2017/03/HDHP-Fact-Sheet-FINAL.pdf

[5] https://altarum.org/sites/default/files/uploaded-publication-files/2017%20Price%20Transparency%20and%20Physician%20Quality%20Report%20Card_0.pdf.

medical services say it was difficult to find information about how much they would have to pay, and 67 percent of those who attempted to negotiate with a provider for a lower price say they were unsuccessful in doing so."[6]

Vermont State Auditor Doug Hoffer had this to say on price and quality transparency in Vermont in a 2014 report:

"Vermont's current health care price and quality transparency system offers patients limited information for making health care decisions. Although the underlying legal structure exists to provide pertinent information, the State has not yet implemented an effective program to help Vermont patients easily compare price and quality information in advance of care, based on their unique situations."[7]

The **Green Mountain Care Board** issued a report in 2015 on price and quality transparency, based on an investigation of the systems that existed then. It found, among other things:

"It is unsurprising, given the relatively recent emergence of health cost and quality transparency websites, that there is little standardization among the 49 consumer sites we examined. Developing and maintaining the sites is both complex and costly, and there are widely diverging opinions on the types of cost data to display, the ways to portray the data, and the integration of quality measures. Although we identify best practices for developing and maintaining these sites in this report, more than a quarter of the sites we reviewed did not adhere to a single best practice and only one public site adhered to all best practices identified."[8]

Cost Sensitivity in Health Care: More Common Than You Think

It is often assumed that most people are adverse to the idea of being cost sensitive when it comes to health care, and that people in HDHPS/CDHPs are more inclined to "shop" for care or to be cost sensitive when choosing between treatment options. But recent studies don't bear this out.

The Journal of the American Medical Association Internal Medicine published a report in February, 2017, by researchers from Harvard University and the University of Southern California. The report found that those in high deductible health insurance plans are really no more likely than those with traditional health insurance to look for less costly care:

*"About **half of those surveyed had high deductibles**—more than $1,250 for an individual and $2,500 for a family. A majority of HDHP enrollees believe there are large differences in prices*

[6] https://www.kff.org/health-costs/report/the-burden-of-medical-debt-results-from-the-kaiser-family-foundationnew-york-times-medical-bills-survey/view/print/

[7] *http://auditor.vermont.gov/sites/auditor/files/documents/Final%20VHCURES%20Report%206.25.2014.pdf*

[8] http://gmcboard.vermont.gov/sites/gmcb/files/documents/GMCB_CIPTR_10012015.pdf

(60 percent) and quality (68 percent) across health care providers, few (17 percent) think higher-priced physicians provide higher quality care, and the majority (71 percent) report out-of-pocket costs are important when choosing a physician. These perceptions are not significantly different than those held by enrollees in traditional plans, according to the results.

"During their last use of medical care, ***HDHP enrollees were no more likely than traditional plan enrollees to consider going to another health care professional for care*** *(11 percent vs. 10 percent)* ***or to compare out-of-pocket cost differences*** *across health care professionals (4 percent vs. 3 percent), the results indicate."*

The study concluded: *"Simply increasing a deductible, which gives enrollees skin in the game, appears insufficient to facilitate price shopping."*[9]

Another study of nearly 3,000 nonelderly Americans, which was published in August, looked at how frequently in the past 12 months those surveyed had price shopped for care and the problems they had encountered. The percentage of those who sought information before getting care was low, **but not because they were opposed to the notion of shopping**:

"Only 13 percent of respondents who had some out-of-pocket spending in their last health care encounter had sought information about their expected spending before receiving care, and just 3 percent had compared costs across providers before receiving care. ***The low rates of price shopping do not appear to be driven by opposition to the idea****: The majority of respondents believed that price shopping for care is important and did not believe that higher-cost providers were of higher quality. Common barriers to shopping included difficulty obtaining price information and a desire not to disrupt existing provider relationships."*[10]

There are massive dimensions of waste in the health care system; for example, excessive administrative charges, unnecessary treatments and missed disease prevention, and fraud, all of which are impervious to "shopping."

The Institute of Medicine, in a landmark study in 2010, estimated that **30% of every U.S. health care dollar is wasted** (in 2009, that amounted to $765 billion; in 2016, it would have meant more than a trillion dollars of wasted spending).

IOM identified three main causes for waste spending: high costs, high administrative expenses, and fraud. It highlighted, too, at least **$210 billion** in unnecessary services and **$55 billion** in missed disease prevention. IOM's findings underscore the critical need for provider-targeted strategies to control costs and incentivize high-quality care.

[9] https://www.sciencedaily.com/releases/2016/01/160119135558.htm
[10] http://content.healthaffairs.org/content/36/8/1392.abstract