HOW DO CONSUMERS RESPOND TO COMPARATIVE COST AND RESOURCE USE INFORMATION?

RESULTS FROM A FOCUS GROUP STUDY SUPPORTED BY THE AHRQ CHARTERED VALUE EXCHANGE

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STUDY BACKGROUND

- Many hope that consumers and patients can play a more active role in keeping down health care costs
- Efforts have already begun to provide comparative information on costs and resources use to the public
- ?? Will this work ??
  - **Will consumers want to look at cost and resource use information? In what context?**
  - **How will they respond? Will they**
    - **Choose an inexpensive provider to save money? OR**
    - **Choose an expensive provider because they equate cost and quality?**

STUDY BACKGROUND

- Study funded by the Agency for Healthcare Research & Quality
- To support the work of the Chartered Value Exchanges (CVEs)
- Team included Judith Hibbard, Jessica Greene, Judith Hirsh and Kirsten Firminger

METHODS

- Phase One: Conduct focus groups with people who have employer based insurance
- Phase Two: Use findings to design randomized trial to test reactions to alternative displays of cost and resource use information
- Today we will look at the results from Phase One

FINDINGS

- Consumers were not interested in information about comparative costs of providers all by itself
- At least half would choose the more expensive provider if shown such information
  - **Because they don't think it would affect their out of pocket costs**
  - **Even if it did, would be have a relatively small effect**
  - **Because they do believe that high cost = better quality**
  - **Because they do not think cost should be a factor in making health care choices – implications for reducing costs???**

FINDINGS

- We asked people why they thought the costs were so different for the two doctors
- In addition to saying the more expensive doctor was providing a higher quality service, including the overall customer service, they suggested:
  - **Location – a more expensive neighborhood would lead to higher prices**
  - **Reputation – a physician with an excellent reputation can "get away with" charging more**
  - **Has been in practice longer**
  - **That is probably impossible to know why!**

Dr. Jones

Charges $ 750

You Pay:
Co-Payment: $150
Deductible: $250

Dr. Howard

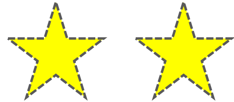
Charges $ 400

You Pay:
Co-Payment: $80
Deductible: $0

FINDINGS

- We explored the notion of “tiering” in which plans reduce or waive co-pays and deductibles for less expensive providers
- People were uncertain why the insurance company would do that
- Some thought the insurance company was trying to save money by encouraging choice of a physician that cost them less
- No one thought this decision was based on variations in quality

Quality of Care Ratings

Dr. Jones 

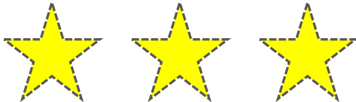
Average

Charges $ 750

You Pay:

Co-Payment: $150

Deductible: $250

Dr. Howard 

Better than Average

Charges $ 400

You Pay:

Co-Payment: $80

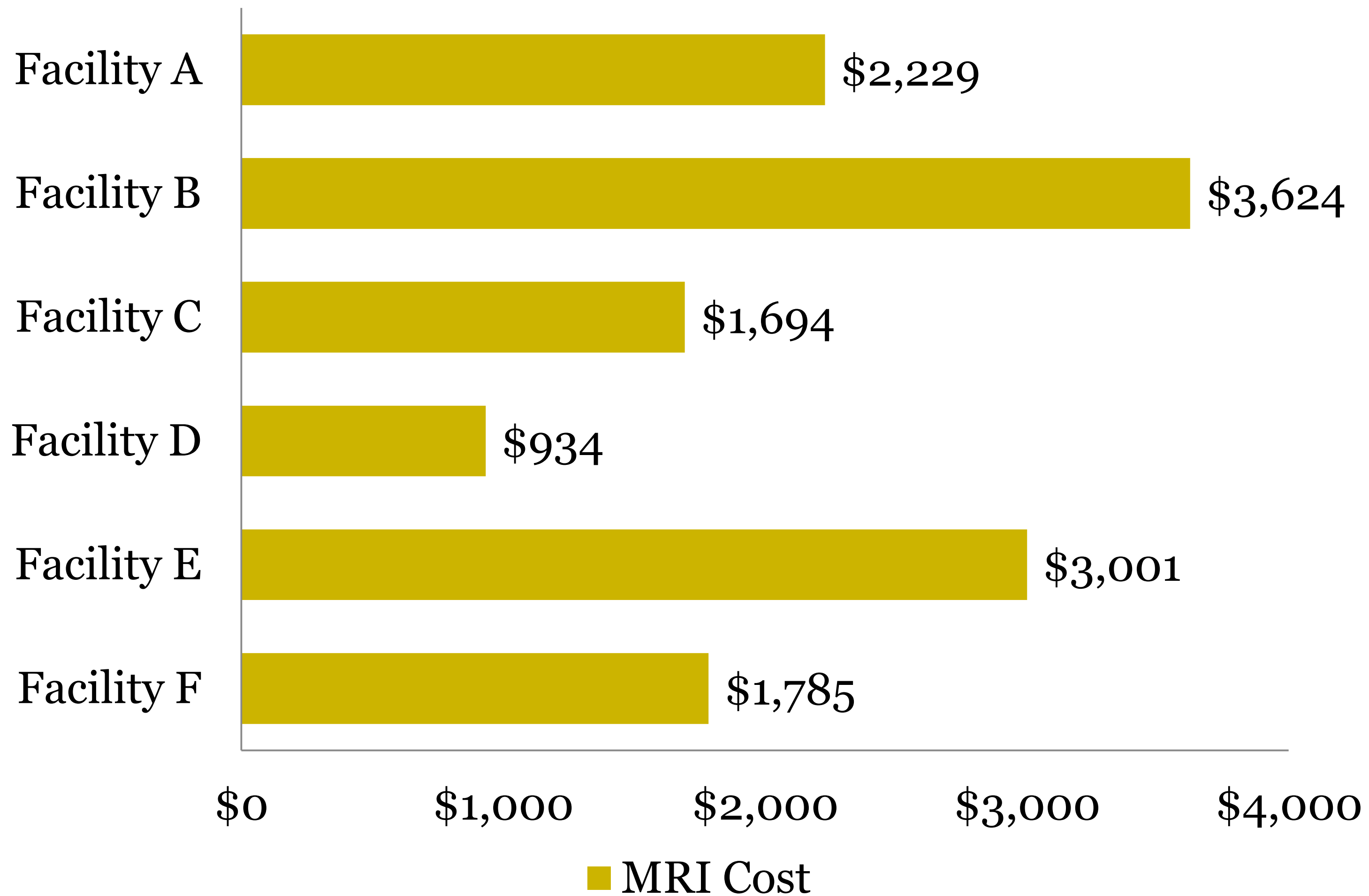
Deductible: $0

FINDINGS

- Then we added quality to the display, where less expensive providers were higher quality
- People were much happier to have quality data along with the cost data
- Many were surprised that the less expensive physician had a higher rating

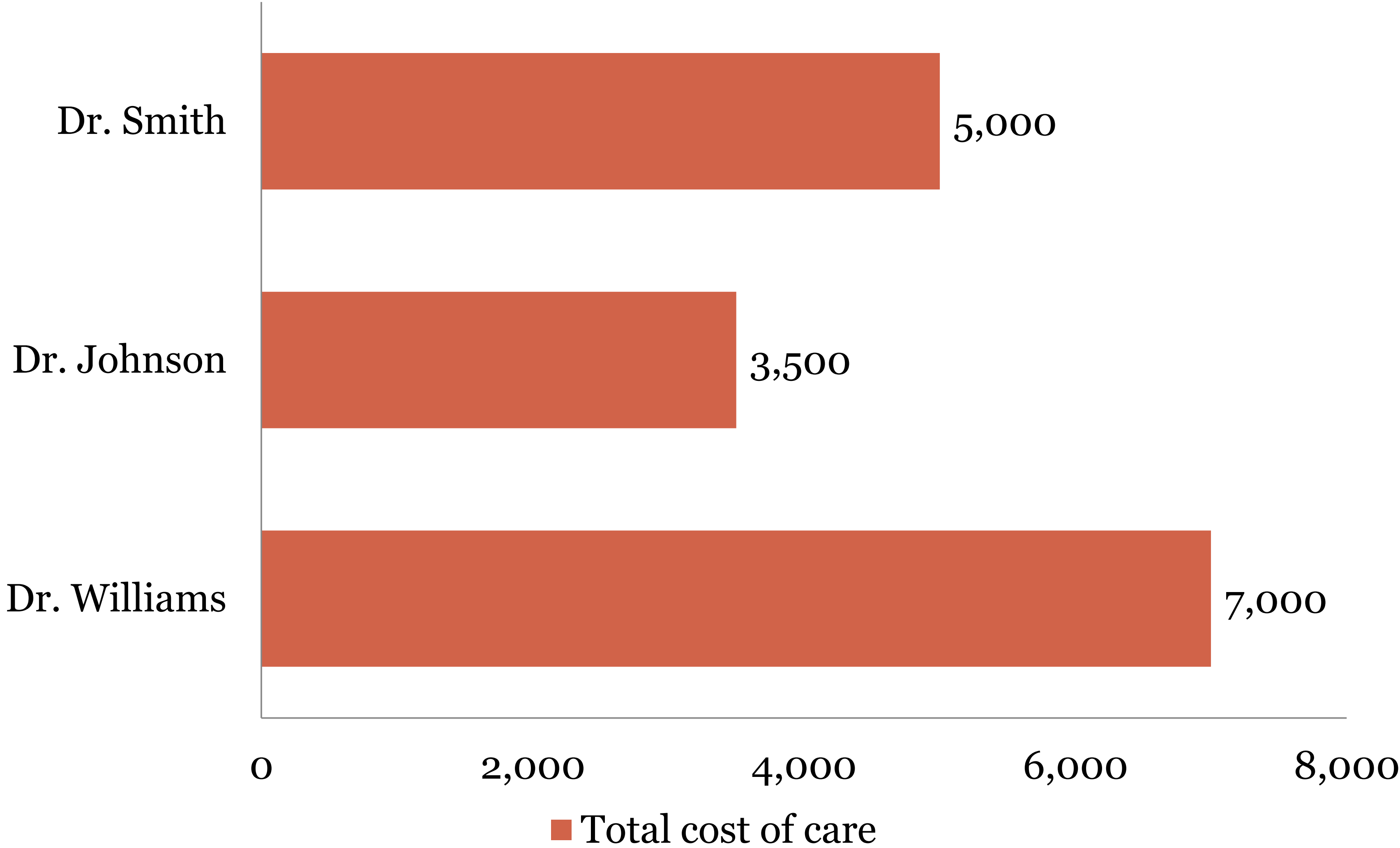
FINDINGS

- Some were then quite willing to choose the less expensive physician, but some were still nervous
  - **Those said they would go with a "mid-priced" provider whose quality was okay**
- When we added in quality in a tiered system, this again more people much more comfortable about taking the cost into account


Cost to get an MRI
Facility A
$2,229
Facility B
$3,624
Facility C
$1,694
Facility D
$934
Facility E
$3,001
Facility F
$1,785
$0
$1,000
$2,000
$3,000
$4,000
MRI Cost

FINDINGS

- We then shifted to a display showing just the costs of a particular procedure, an MRI
- People were somewhat but not entirely surprised by the wide range of prices at different facilities
- Absent quality information, some would go to the higher price facilities, while others would steer toward those in the middle tier
- Almost all, again with exceptions for people with very high deductibles, would avoid the lowest cost providers


Yearly cost of care for heart disease
Dr. Smith
Dr. Johnson
Dr. Williams
5,000
3,500
7,000
0
2,000
4,000
6,000
8,000
Total cost of care

FINDINGS

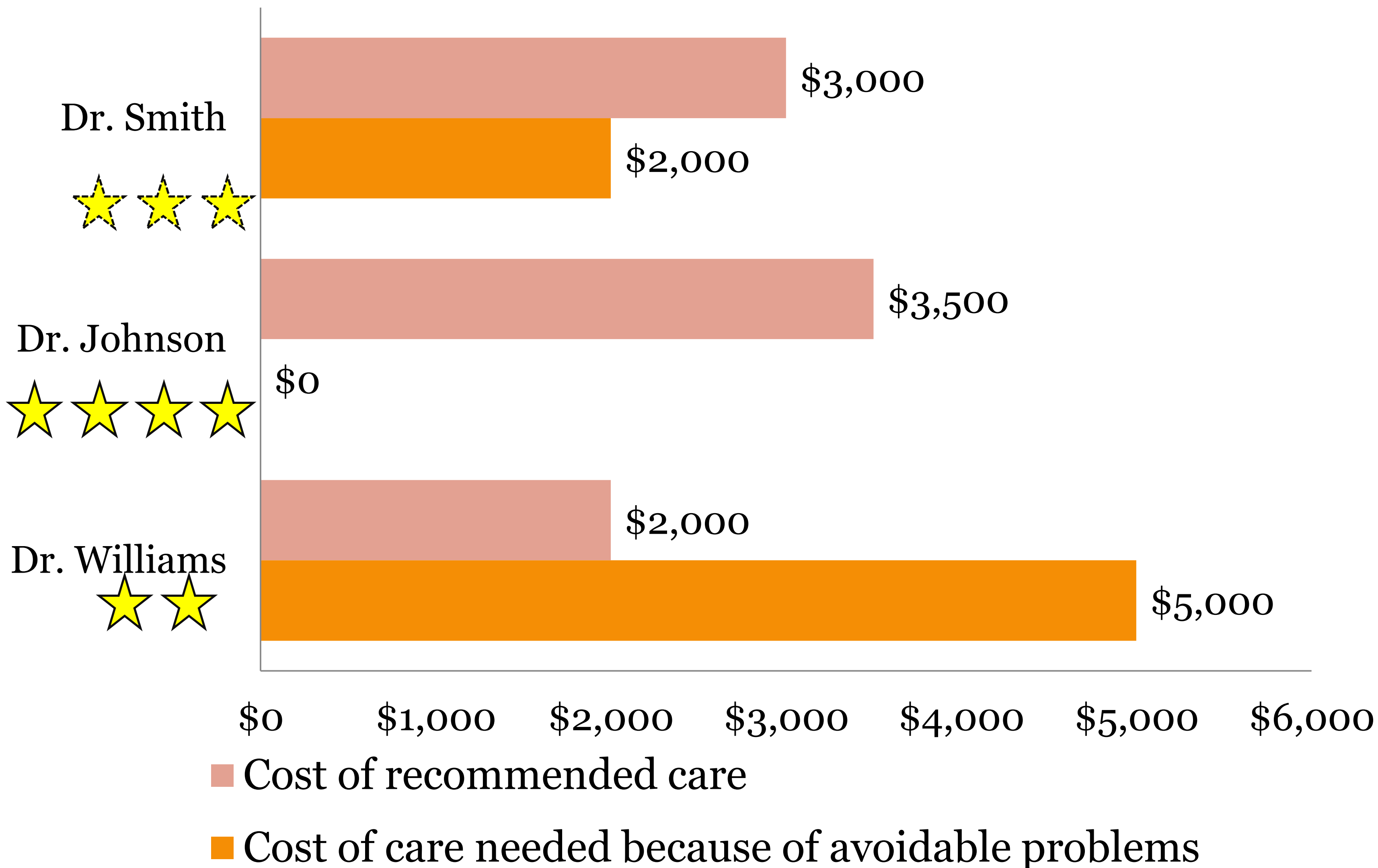
- Another kind of cost metric is the total annual cost for a patient with a specific illness
- Given only the costs, people assumed that those with a higher cost were in fact doing more for their patients
- **They assumed that doing more was a good thing**

FINDINGS

- So we gave them a display that added in quality
- In this case, quality and cost had an inverse relationship
- People found this pretty counter-intuitive and somewhat confusing
  - **Why would the quality be higher if you were taken care of by a physician whose costs were lower?**

FINDINGS

- In the final display in this series, we broke down the costs, using the approach of the Prometheus payment model, into two “buckets”
  - **The cost of recommended care**
  - **The cost of care needed because of avoidable problems**
- In this display, we were making the point that spending money on recommended care led to better quality and that money spent on care for avoidable problems was a sign of lower not higher quality


Yearly cost of care for heart disease
Dr. Smith
Dr. Johnson
Dr. Williams
$3,000
$2,000
$3,500
$0
$2,000
$5,000
$0
$1,000
$2,000
$3,000
$4,000
$5,000
$6,000
Cost of recommended care
Cost of care needed because of avoidable problems

FINDINGS

- **People interpreted the cost data in this display as quality data**
- They really liked the idea of finding out which physicians' patients had avoidable complications
- The idea of "complications" really resonated with them as a sign of poor quality, although some noted that lack of patient compliance could also lead to such complications

TAKE AWAY MESSAGES

- Focus cost information on costs to the individual, not overall costs (except for metrics strongly tied to quality)
- Do not provide cost or resource use information by itself – link it to quality information
- Provide the data in ways that help people change their mind set about the relationship of cost and quality
- Note: In general, current presentations of cost do not use this approach!

MORE TO COME

- The team then did a lab study which we cannot cover today, but it basically confirmed and extended focus group findings
- In particular, not only was it important to provide quality as well as cost information
  - **It was better if the "quality signal" was very strong**
  - **It was better if the display "interpreted" the data for people by calling out the best value providers**

MORE TO COME

- We have more complete slides sets on both parts of the study for those who are interested
- Better still, we hope that both parts of the study will be published in an upcoming *Health Affairs* special issue, along with other papers about public reporting
- Questions?