WHAT DO CONSUMERS REALLY VALUE IN HEALTH CARE?

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BOSTON, MA

Mark A. Kelley, M.D. is a physician educator at Massachusetts General Hospital where he is the Director of the Faculty Leadership Initiative for the Department of Medicine. He is also a visiting scholar at Harvard Business School and an advisor to its MD-MBA program. In 2013, Dr. Kelley was as an Advanced Leadership Fellow at Harvard University, where he studied health care economics and policy at the Kennedy School of Government.

After his undergraduate and medical education at Harvard, Dr. Kelley trained in internal medicine, and pulmonary-critical care at the Hospital of the University of Pennsylvania. As professor of medicine at Penn, he served in a variety of leadership positions including Vice Chair of Medicine, and Vice Dean for Clinical Affairs, when he led physician and hospital network development of the University of Pennsylvania Health System. Prior to those responsibilities, he directed the pulmonary-critical care fellowship as well as the internal medicine residency program.

From 2000-2012, Dr. Kelley served as Executive Vice President and Chief Medical Officer for the Henry Ford Health System, one of the nation’s leading integrated delivery systems. He was also the Chief Executive Officer of the Henry Ford Medical Group, one of the nation’s largest academic group practices and was responsible for quality, research and educational programs across the System. There, he also developed the Physician Leadership Institute, which is named in his honor.

During Dr. Kelley’s twelve years at Henry Ford, the Health System received the following recognitions for health care quality: the Codman Award from the Joint Commission, the John Eisenberg Award from the National Quality Forum, and the Baldrige Award from the U.S. Department of Commerce.

Dr. Kelley is a published authority in medical education and physician workforce and has won numerous teaching awards. He has served as chairman of both the American Board of Internal Medicine (ABIM) and the ABIM Foundation. He has been a director of the Accreditation Council for Graduate Medical Education; the American Board of Medical Specialties; and the American Medical Group Association (AMGA). He has also served on the HHS Council on Graduate Medical Education (COGME). He is currently a commissioner for The Joint Commission, which accredits hospitals and other health care organizations. He is the chair of that organization’s Standards and Survey Committee.
OBJECTIVES:
Participants should be better able to:

1. Understand how consumers use public quality reports;
2. Understand the current state of health costs and inflation;
3. Understand how insurance redesign (deductibles, co-pays) affects patients;
4. Understand how patients make health care decisions.
What Do Consumers Really Value in Health Care?

March 24, 2017
Mark A. Kelley, M.D.
Massachusetts General Hospital

Topics for Today

- Do consumers understand health care quality?
- Health costs and consumer behavior
- What do consumers really want (need)?
- Will consumerism force changes in health care?
Topics for Today

- Do consumers understand health care quality?
- With more out of pocket costs, how are consumers reacting?
- What do consumers really want (need)?
- Will consumerism force changes in health care?

Health Care Quality “Forces”

- National Quality Forum
- Institute for Healthcare Improvement
- NCQA
- AHRQ
- The Joint Commission
Health Care Quality Initiatives:
(A Few Examples Among Many)

- AHRQ Report 2011:
  - 50% improvement in AMI intervention speed
  - Slight improvement in routine screening
  - Lifestyle modification negligible

- Hospital Safety:
  - IHI 100,000 Lives Campaign
  - “Checklists” and “Bundles”
    - error prevention
Q.1 Health care is more reliable than air travel

True or False?

False: Health Care Is NOT Highly Reliable
(Chassin and Loeb, Milbank Quarterly, 2013; 91:459–490)

- High reliability organizations rarely have accidents
  - Airlines (1.6 deaths/Million flights : 88% improvement in one decade)
  - Nuclear Power Plants –essentially never

- Annual statistics for U.S. hospitals:
  - 99,000 deaths from hospital acquired infections
  - 600 Operating Room fires
  - Wrong-side surgery 50 times/week
Q.2 Patients rely on publicly reported quality outcomes to make decisions

True or False?

False: Consumers are Not Using Public Reporting to Make Health Decisions (Kaiser Family Foundation 2008)
How Do Consumers Find the “Best Hospitals”? 

“Hospital Compare”: 
(Is this Lake Wobegone?)

“South Shore” of Boston (20-30 miles from downtown
- Mass General (900 beds) – large urban academic medical center downtown
- South Shore Hospital (284 beds) – mid-sized suburban hospital in Weymouth, MA
- Jordan Hospital (150 beds) – in Plymouth, MA.
“Hospital Compare” : CHF Outcomes
(% of patients within 30 days of admission)

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<tr>
<td>Mortality</td>
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<td>12</td>
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What do these statistics mean to you?

CHF Outcomes: Boston vs. Detroit
(% within 30 days of admission)

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Conclusion?
CHF Outcomes: Boston vs. Detroit
( % within 30 days of admission)

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<td>12</td>
<td>11</td>
<td>8</td>
<td>9</td>
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Conclusion – MOVE TO DETROIT?

National Hospital Ratings Systems Share Few Common Scores And May Generate Confusion Instead Of Clarity

“No hospital was rated as a high performer by all four national rating systems. Only 10 percent of the 844 hospitals rated as a high performer by one rating system were rated as a high performer by any of the other rating systems”

Health Affairs 2015; 34:423-430
DATAWATCH

US Physician Practices Spend More Than $15.4 Billion Annually To Report Quality Measures

Each year US physician practices in four common specialties spend, on average, 785 hours per physician and more than $15.4 billion dealing with the reporting of quality measures. While much is to be gained from quality measurement, the current system is unnecessarily costly, and greater effort is needed to standardize measures and make them easier to report.
How Do Consumers View Health Care Quality Compared to Aviation?

Topics for Today

- Do consumers understand health care quality?
- Health costs and consumer behavior
- What do consumers really want (need)?
- Will consumerism force changes in health care?
Q.3 Since the recession, health care inflation has remained low

*True or False?*

Health Care Growth *Was* Declining!
*(Cutler, Health Affairs, May 2013)*

![Graph showing factors accounting for growth in per capita national health expenditures and personal health care expenditures, 2004-11.](chart)
Why Did Health Growth Decline?

- **One-Time Cuts** (explain 50%)
  - Recession
  - Medicare cuts to Medicare Advantage, hospitals and home health

- **Industry changes**:
  - Tiered drug benefits
  - Fewer new blockbuster technology/drugs
  - Shift to outpatient

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OOPS!

*Health Affairs: 35, 2016; 150*
Health Inflation Overcoming GDP(again)

*Health Affairs* 26, 2017;166

**EXHIBIT 2**

Growth in national health expenditures (NHE) and gross domestic product (GDP), and NHE as a share of GDP, 1989-2015

<table>
<thead>
<tr>
<th>Year</th>
<th>NHE as a Share of GDP</th>
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<tbody>
<tr>
<td>7/90-3/91 recession</td>
<td>11.4%</td>
</tr>
<tr>
<td>3-11/01 recession</td>
<td>13.3%</td>
</tr>
<tr>
<td>12/07-6/09 recession</td>
<td>7.7%</td>
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</tbody>
</table>

[Sources: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; US Department of Commerce, Bureau of Economic Analysis; and National Bureau of Economic Research Inc.]

Private Health Insurance Drives Inflation

*Health Affairs* : 34, 2015; 2147

**Average Standardized Payment Rates Per Inpatient Hospital Stay, By Primary Payer, 1996-2012**

- **Private Health Insurance**
- **Medicare**
- **Medicaid**

[Sources: Authors' analysis of data for 1996-2012 from the Medical Expenditure Panel Survey. Notes: The average payment rates were computed as if each primary payer paid for all nonmaternity adult stays in a given year. Payments were adjusted for inflation and standardized across payers in terms of patient's age, sex, race/ethnicity, geography, household income as a percentage of the federal poverty level, condition charges, length-of-stay, and whether or not a surgical procedure was performed. They were not standardized for changes over time in the bundles of treatments and services provided during inpatient stays. Estimates and standard errors can be found in online Appendix F and Appendix Table F.1 (see Note 9 in text).]
Q.4 50% of the US population accounts for 5% of health costs

True or False?

TRUE! : Concentration of Health Care Spending in the U.S. Population, 2010

NOTE: Dollar amounts in parentheses are the annual expenses per person in each percentile. Population is the civilian noninstitutionalized population, including those without any health care spending. Health care spending is total payments from all sources (including direct payments from individuals and families, private insurance, Medicare, Medicaid, and miscellaneous other sources) to hospitals, physicians, other providers (including dental care), and pharmacies; health insurance premiums are not included.

Q. 5 High deductible health plans reduce health care expenditures

*True or False?*

*True or False: depending on who you ask!*
New Factor – Employee Cost-Sharing

- Over 30% of insured employees have deductibles over $1000 (24% increase over six years)
- At least 50% have office visit co-pays over $25
- Median income fell 6.3% from 2001-2011
- Office visits fell 17% from 2009-2011

(Cutler, Health Affairs, May 2013)

High-Deductible Health Plans Are Here to Stay

- Employers want to curb premiums
- Businesses considering defined contribution plans
- Most consumers, sick or not, choose high deductible plans to reduce premiums

(Wharam, NEJM Oct. 7, 2013)
Deductibles

- Like auto insurance, the consumer pays medical bills up to a limit before the insurance company begins to pay.

- **Deductibles use first dollar consumer payment to offset any increases in employer premiums.**

- Deductibles can include partial or total costs of a drug, a procedure, test, doctor visit, or going out of network.

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Percentage of nonelderly adults with employer-sponsored insurance facing health care burden exceeding 20 percent of family income, by income and deductible level, 2011–13.

Salam Abdus et al. Health Aff 2016;35:2297-2301
Health Care Poses Financial Risk Even for Insured Patients
(Ubel, NEJM 10/17/13)

"This approach of shifting more of the cost to employees amounts to rationing ...and delegates the bulk of the hoped-for belt-tightening to low-income families. “
Out of Pocket Costs By Insurance Category: Medicare Is Expensive!

Health Affairs: 34, 2015; 111

<table>
<thead>
<tr>
<th>Insurance category</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
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</thead>
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<tr>
<td>Employer-sponsored insurance</td>
<td>$ 779</td>
<td>$ 804</td>
<td>$ 803</td>
<td>$ 836</td>
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<tr>
<td>Individually purchased coverage</td>
<td>1,003</td>
<td>1,078</td>
<td>1,076</td>
<td>1,034</td>
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<tr>
<td>Medicaid</td>
<td>190</td>
<td>210</td>
<td>183</td>
<td>188</td>
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<tr>
<td>Other</td>
<td>---</td>
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<tr>
<td>Medicare [all]</td>
<td>2,568</td>
<td>2,473</td>
<td>2,465</td>
<td>2,530</td>
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<tr>
<td>Dual eligibles</td>
<td>2,634</td>
<td>2,501</td>
<td>2,435</td>
<td>2,562</td>
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<tr>
<td>Non-dual eligibles</td>
<td>2,546</td>
<td>2,467</td>
<td>2,470</td>
<td>2,520</td>
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<tr>
<td>Uninsured</td>
<td>599</td>
<td>656</td>
<td>626</td>
<td>541</td>
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Annual Growth

<table>
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<tr>
<td>Employer-sponsored insurance</td>
<td>---%</td>
<td>33%</td>
<td>-0.2%</td>
<td>4.1%</td>
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<tr>
<td>Individually purchased coverage</td>
<td>---%</td>
<td>7.4</td>
<td>-0.2</td>
<td>-3.9</td>
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<tr>
<td>Medicaid</td>
<td>---%</td>
<td>10.4%</td>
<td>-13.0</td>
<td>3.0</td>
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<tr>
<td>Other</td>
<td>---%</td>
<td>---%</td>
<td>---%</td>
<td>---%</td>
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<tr>
<td>Medicare [all]</td>
<td>---%</td>
<td>-3.7%</td>
<td>-0.3</td>
<td>2.7</td>
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<tr>
<td>Dual eligibles</td>
<td>---%</td>
<td>-6.8%</td>
<td>-2.7</td>
<td>6.0</td>
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<tr>
<td>Non-dual eligibles</td>
<td>---%</td>
<td>-3.1%</td>
<td>0.1</td>
<td>2.0</td>
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<tr>
<td>Uninsured</td>
<td>---%</td>
<td>9.4</td>
<td>-4.5</td>
<td>-136</td>
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Benefit Design Outcomes: Research to Date

- **High Deductible Plans** reduce costs but adversely effect low income and chronic disease patients
- **Value-based Insurance** (using financial incentives to direct patients): can improve adherence, minimal benefit on outcomes; may improve savings
- **Tiered pharma benefits**
  - Reduce costs without reducing use of health services
  - Drug adherence declines with high co-pays or lack of generic option

*Center for Healthcare Research, U. Michigan*
*Nov. 2013*  www.chrt.com
“Doctor, First Tell Me What It Costs”
(Peter Ubel, NY Times November 3, 2013)

“Patient Costs Skyrocket: Specialists’ Incomes Soar”
(NY Times January 18, 2014)

To Patients, Health Care is a Alien Environment
- Prices outrageous and incomprehensible
- Hard to access the system and personal information
- “Retail” services fall short of other service industries
- Care is uneven and sometimes dangerous
- BUT – most hospitals and docs are “OK”
Topics for Today

- Do consumers understand health care quality?
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- What do consumers really want (need)?
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How do Patients Make Health Care Decisions?

- Price
- Convenience
- Word of Mouth
  - Ambience/Service
    - Quality Reports
    - Marketing
Consumers’ View of Health Care Costs  
*(RWJ Issue Report October, 2012)*

- Consumers see costs as *what they pay for* health care, including insurance.
- Little understanding of why costs are rising.
- Costs are hitting the family budget and forcing economic tradeoffs – *resulting in fear and anger*.
- High price linked to location – not quality!

“Measuring Health Outcomes”  
*(Porter, NEJM Dec. 2010)*

**Tier 1** – Health Status Achieved  
**Tier 2** – Process of Recovery  
**Tier 3** – Sustainability of Health

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**Tier 1: Health Status Achieved**
- **Survival**
  - Mortality rate (inpatient)
- **Degree of health or recovery**
  - Functional level achieved
  - Pain level achieved
  - Leisure of return to physical activities
  - Ability to return to work

**Tier 2: Process of recovery**
- **Time to recovery**
  - Time to begin treatment
  - Time to return to physical activities
  - Time to return to work
- **Disability of care or treatment process**
  - Delay and anxiety
  - Pain during treatment
  - Length of hospital stay
  - Infection
  - Pulmonary embolism
  - Deep-vein thrombosis
  - Myocardial infarction
  - Need for re-operation
  - Delays

**Tier 3: Sustainability of Health**
- **Sustainability of health or recovery**
  - Maintained functional level
  - Ability to live independently
  - Need for revision or replacement
- **Nature of recurrences**
  - Loss of mobility due to inadequate rehabilitation
  - Risk of re-fracture
  - Sustaining infection
  - Difficulties due to unrecognized complications
  - Regional pain syndrome
We are Not There Yet!

“A 2013 Hip Replacement Looks Like a 1954 Buick”

(Steinmetz and Emanuel, JAMA Intern Med, 2013; 173: 432-434)

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Price Transparency Can Change Hospital Choice for Joint Surgery
*(Health Affairs Oct. 2013)*

Patients Choosing High-Price or Low-Price California Hospitals For Knee Or Hip Replacement Surgery, 2008-12

Price Transparency Can also Change Hospital Prices for Joint Surgery
*(Health Affairs Oct. 2013)*

Prices Paid For Knee And Hip Replacement Surgery In High-Price And Low-Price California Hospitals, 2008-12
“Shoppable” Health Care Limits

NIHCR Research Brief on Reference Pricing
www.nihcr.org/reference-pricing2

“Reference Pricing”: Small Impact?

NIHCR Research Brief on Reference Pricing
www.nihcr.org/reference-pricing2
Out of Pocket Costs (OPCs)

- What you must pay the insurance company (or the provider) when you receive service

- INCLUDE co-pays, co-insurance, and deductibles

- *Premiums are not considered OPCs*

The ACA and Out of Pocket Costs

- The ACA limits OPCs to $6360 for individual and $12,750 for a family

- This does NOT include costs of premiums

- Average *premium* for a high deductible plan:
  - $5,000 for an individual
  - $14,000 for a family

- Total exposure could be $20,000 for a typical family
What Do Patients Want?

Personal Medical Service
- Caring providers who know them
- Access to those providers
- Affordable, safe, effective and understandable health care

Tools (we are not providing):
- Portable/shared health records
- Connection – Web, video, social media
- Care out of the office: virtual visits, monitoring

...What Are Patients Getting?

Ask CMS

“Bundled Payment”: fixed price for a “process/procedure” – no data – might work – invisible to patient

Accountable Care (ACO’s) – providers take insurance risk; works for some large, experienced groups – limits patient choice

“Short Stay Penalty” – the Midnight Rule: CMS misunderstands its own regs – a PR disaster
Where is Health Care Going?  
...Storm Clouds on the Horizon

- **Quality “Seen and Unseen”**
  - “Retail” – what you see and feel (HCAHPS )

- **Pharmaceutical “Mayhem”**- sticker shock of biologics; corporate manipulation of generics (EpiPen) *Is anyone fixing this?*

- **Insurance Defections from ACA exchanges** *Are we headed toward single payer?*

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Let’s Play The Congressional “Jenga” Game
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- With more out of pocket costs, how are consumers reacting?
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Efforts from the Profession

“The Conversation Project”
The Future Has Already Arrived

The Demise of the “Local Drug Store”

Before
“Mom and Pop”

Now
National Corp.
HealthWeb Navigator

Finding the Best Health Information On the Web

www.healthwebnav.org

The Future?

- Government and business will use insurance redesign as a lever but, alone, it will NOT solve health inflation -- *we need to eliminate waste*!
- Patients will increasingly weigh health care value -- *when pressed, they will ration their own care*
- The public will rely on the profession to improve quality and safety – *if that fails, they will demand regulation*
- The nation is inexorably moving toward a single payer supported by taxes – *like the rest of the world*
How Do We Want Patients To View Us?

- Health costs are risk factors—Become experts in health insurance and costs—our patients need us
- Almost all patients have prescribed drugs—manage them prudently
- Continue leadership in explaining to patients: the why, what, how and costs of tests, procedures and treatments; end-of-life choices

How Can We Help Patients Now?