



LESSONS LEARNED

Consumer Beliefs and Use of Information about Health Care Cost, Resource Use, and Value

Findings from Consumer Focus Groups

October 2012

Increased investments in transparency—particularly of health care cost and resource use information—are meant to address the challenges of rising costs and inefficient care. However, the ability of these efforts to improve the return on our health care dollars largely rests on how well consumers are able to understand and appropriately apply comparative information on costs and resource use to their health care decisions.

This report summarizes findings from eight consumer focus groups conducted by the American Institutes for Research to support efforts by the Robert Wood Johnson Foundation's 16 *Aligning Forces for Quality* (AF4Q) communities to publicly report cost and efficiency information.

Specifically this report aims to answer the following questions:

1. What core beliefs do consumers hold about health care costs?
2. What factors influence a consumer's interest and trust in cost information?
3. When do consumers find cost and resource use information most useful for decision making?
4. Do consumers find certain measures—such as readmissions and avoidable complications data—useful?
5. How do consumers think about health care “value?” How does this differ from the “value” of other consumer goods?
6. What factors influence whether consumers perceive common network and benefit designs as fair?

The findings from AIR's report, which were informed by access to concurrent research efforts funded by the Agency for Healthcare Research and Quality (AHRQ)—will result in specific displays and messages that can be used in public reports to help consumers understand and use information about cost, resource use, and value in the near future to make informed decisions.

About *Aligning Forces for Quality*

Aligning Forces for Quality (AF4Q) is the Robert Wood Johnson Foundation's signature effort to lift the overall quality of health care in targeted communities, as well as reduce racial and ethnic disparities and provide real models for national reform. The Foundation's commitment to improve health care in 16 AF4Q communities is the largest effort of its kind ever undertaken by a U.S. philanthropy. AF4Q asks the people who get care, give care and pay for care to work together to improve the quality and value of care delivered locally. The Center for Health Care Quality in the Department of Health Policy at George Washington University School of Public Health and Health Services serves as the national program office. Learn more about AF4Q at www.forces4quality.org. Learn more about RWJF's efforts to improve quality and equality of care at www.rwjf.org/goto/af4q.

About the Author

American Institutes for Research (AIR) provides technical assistance for the Robert Wood Johnson Foundation's *Aligning Forces for Quality* initiative. AIR is working with *Aligning Forces* communities to support consumer engagement efforts to promote higher-quality health care at a lower cost.

	Focus Group	Health Status	Type of Plan	Location
Round 1	Groups 1 & 2	Chronic conditions	HMO or PPO	Baltimore, MD
	Groups 3 & 4	Non-chronic conditions		
Round 2	Groups 5 & 6	Chronic conditions	High-deductible Plan	Raleigh, NC
	Groups 7 & 8	Non-chronic conditions		

Methods (Appendix)

- Eight focus groups with consumers over two rounds of testing
- Participants were 18 to 64 years old with mix of race, gender, education, income, ethnicity

Summary of Findings (pg. 3-6)

1. Consumers find information on the cost of care difficult to obtain and understand.
2. Consumers attribute variations in cost to differences in quality, location, negotiated rates, and funding sources.
3. Consumer interest in applying cost information to decision-making depends on a number of interrelated personal factors, including their level of exposure to out-of-pocket costs, the severity and urgency of their condition, and preconceptions about provider quality.
4. Consumers find information on out-of-pocket costs more meaningful and useful than other types of cost information.
5. Consumers are more likely to trust cost information from organizations that are reputable and do not have a financial motive in presenting the information.
6. Consumers define “getting good value” from their provider as receiving patient-centered care that demonstrates high technical proficiency.
7. While consumers find readmission and complication measures compelling, they are not meaningful or useful by themselves.
8. Consumers are more likely to perceive benefit designs that provide several options—and where all options meet minimum quality standards—as fair.

Previous Findings from Focus Groups

This report confirms and builds upon previous research led by AIR that found consumers hold the following beliefs about health care:

- All care meets minimum quality standards
- Medical guidelines are inflexible
- More care and newer care is better
- More costly care is better

Summary of Recommendations (pg. 6-7)

Dissemination and Reporting

- Always present quality information alongside cost information.
- Focus on reporting costs for “shoppable” conditions and procedures.
 - *Provide easy access to information emphasizing your Alliance’s independence and expertise and to the data sources and methods used to calculate the measures.*

One Consumer’s Perspective

“Sometimes what I’ve run into, I’ll start with the doctor: – ‘How much is it?’ ...The answer has been, ‘You’ve got to ask the insurance company...’ So then we call Blue Cross Blue Shield and say, ‘How much is it? And they know how much they’re going to pay, but their answer to me is, ‘We can’t tell you that information. It’s proprietary.’”

- *Include contextual language that clearly explains why the information is being presented, how to interpret the information, and what the information says about each provider’s care.*
- *Test measures, contextual language, displays, and labels before including them in a public report.*

Stakeholder Engagement

- Inform consumers that intensity of treatment drives up costs, unnecessary treatment can be not only wasteful but also harmful, and high-quality care can be obtained at a reasonable cost.
- Work with self-insured employers and insurers to facilitate access for consumers to information on out-of-pocket costs.
- Work closely with employers that offer high-deductible plans to implement value-based insurance designs that provide significant financial incentives to consumers for choosing more efficient care, and communicate to consumers that the purpose of the designs is not purely to lower costs, but also to promote good-quality care at lower costs.

Findings

1. Consumers find information on the cost of care difficult to obtain and understand.

Consumers find information on health care costs very difficult to **obtain** for many reasons:

- **Plans consider their cost information to be proprietary.** Competitive reasons discourage plans from willingly sharing certain types of cost information with patients before they are treated.
- **Providers often do not have information on costs of procedures to share with consumers.** As a result, consumers report often not knowing what certain procedures will cost them out-of-pocket until the bill arrives.

When they are exposed to information on health cost, consumers find the information difficult to **understand** for the following reasons:

- **Consumers often receive their bills in pieces—and long after they have received treatment for a procedure or episode of illness.** Consumers report that it is not unusual to receive separate bills from their surgeon, anesthesiologist, laboratory, and hospital—all for a single procedure or episode. Furthermore, these bills arrive long after treatment is complete, placing a significant burden on the consumer to determine their total out-of-pocket responsibility, as well as the total actual cost.
- **Costs are exorbitant—often without justification.** Consumers have trouble understanding why costs of everyday items such as an aspirin or facial tissues are so much more expensive when they receive a bill from their provider than when they obtain them in a store.
- **Consumers do not receive adequate assistance with understanding their bills.** When consumers have questions about their bills, they do not receive adequate help understanding them from providers or their health plans.

2. Consumers attribute variations in cost to differences in quality, location, negotiated rates, and funding sources.

Consumers do not attribute variations in cost to unneeded care or treatment intensity. Rather, they believe variations in provider costs are the result of differences in:

- **Quality.** Due to experience with other commercial goods and services, many consumers believe that cost is an indicator of provider quality and that “you get what you pay for.”¹ Thus, many consumers assume higher-cost hospitals or doctors’ offices have more knowledge, experience, staff, and amenities or provide more specialized care.

One Consumer’s Perspective

“I would say the question here is not so much what the cost is. It’s actually how much do I have to pay?”

Who is Interested in Cost Information?

A consumer with **more** interest in cost information may have one or many of the following:

- a high-deductible plan
- a non-urgent or non-severe condition, or no health problems
- need for a new doctor and no preconceived notions about the quality of certain providers

A consumer with **less** interest in cost information may have one or many of the following:

- a traditional insurance plan (HMO/PPO)
- a need for urgent care or treatment for a severe condition
- a doctor whom they like, or preconceived notions about the quality of certain providers

- **Location.** Specifically when looking at hospital costs, consumers are quick to attribute differences to the location of the hospital.

- **Negotiated rates.** In the case of co-payment differences between physicians, consumers are quick to assume that the higher-cost physicians have negotiated higher co-payment rates with the insurance company.

- **Funding sources.** In justifying differences in hospital costs, consumers stated that the higher-cost hospitals may be private hospitals, which do not benefit from public funding.

3. Consumer interest in applying cost information to decision-making depends on a number of interrelated personal factors, including their level of exposure to out-of-pocket costs, the severity or urgency of their condition, and preconceptions about provider quality.

Consumers demonstrate a greater interest in applying cost information to their care decisions when they have:

- **A high level of exposure to out-of-pocket costs.** Consumers who are aware they have a strong financial incentive to use cost information—due to high-deductible health plans (CDHPs/HDHPs), poor or no coverage, more frequent provider visits, value-based insurance designs, or a combination of the above—are **more likely** to use cost information.
- **A non-severe, non-urgent condition.** Consumers who have time to shop for care and do not have a severe or urgent condition for which they need prompt, high-quality attention are **more likely** to use cost information.
- **Few or no preconceptions about the quality of providers.** Consumers who have not been influenced by advertising, word-of-mouth, or a previous positive personal experience will be **more likely** to apply cost information to their decision-making.

4. Consumers find information on out-of-pocket costs more meaningful and useful than other types of cost information.

Although organizations can report several types of cost measures—costs of an episode, costs of potentially avoidable complications, total average costs, to name a few—consumers find information on their own out-of-pocket costs to be the most meaningful and useful.

5. Consumers are more likely to trust cost information from organizations that are reputable and do not have a financial motive in presenting the information.

Consumer trust in sources of cost information is heavily influenced by the following factors:

- **Reputation.** Consumers are more likely to trust information from sources they perceive as reputable. This factor is subjective and varies from consumer to consumer and may depend on several factors, including a website's appearance and the participation or endorsement of key stakeholders.
- **Financial motive in presenting the data.** When consumers feel an organization has a strong financial self-interest to keep costs down for the purposes of profit—such as an employer or health plan—they are skeptical of its motives in presenting cost information.

While consumers also express concern that independent, non-profits also may be influenced by funding sources, they tend to trust these organizations more than employers and insurers as sources for information on health care cost.

6. Consumers define “getting good value” from their provider as receiving patient-centered care and care that demonstrates high technical proficiency.

Most consumers are shielded from costs when seeking treatment. So, predictably, cost is *not* top-of-mind when consumers think about “value” when obtaining care from their health care provider. Instead, consumers believe that they are “getting good value” when they receive what they perceive to be high-quality care; in other words, when their provider:

- **Takes time during the appointment.** Consumers feel they have received good value when their provider does not rush them out the door, but instead takes time to answer questions and address the consumer’s needs.
- **Is easily accessible.** Consumers feel they have received good value when a provider is easily reachable, available for appointments on short notice, and conveniently located. Short wait times and personal attention (e.g., they see the doctor rather than the physicians’ assistant) also signal “good value.”
- **Communicates well with patients.** When their providers are responsive to patient needs, listen well, and exhibit good “bedside manner,” consumers feel they have received good value.
- **Demonstrates knowledge and technical proficiency.** Consumers feel they have received good value when they have a doctor who appears knowledgeable, knows the patient’s medical history, has good credentials and training, and provides proper follow-up.

One Consumer’s Perspective

“I want somebody that’s going to listen to me... if I sit in there and ask her 1,500 questions, she will sit there and answer 1,500 questions.”

7. While consumers find readmission and complication measures compelling, they are not meaningful or useful by themselves.

Consumers find certain **resource use measures**—such as 30-day readmission and avoidable complication rates—compelling because they can also be indicative of poor outcomes. Therefore, these measures may have potential as useful measures to report to consumers. However, without additional contextual information, consumers, as well as many providers, are unclear about who is responsible for those outcomes—the patient (due to lack of adherence) or provider (due to improper care or patient education). Moreover, consumers are unsure whether a poor readmission or complications rate could be the result of a provider seeing sicker patients without the following additional information:

- **Cause of the readmission or complication.** Did the patient do what he or she was told? Did the doctor or hospital fail to follow a certain process?
- **Type of medical conditions reflected in the population.** Does this doctor or hospital specialize in seeing a certain type of patient who might be more susceptible to readmissions or complications?
- **Explanation about whether the results take into account doctors who see sicker patients.** If a doctor is seeing sicker patients, have the scores been adjusted to account for this?

8. Consumers are more likely to perceive benefit designs that provide several options from which to choose—and where all options meet minimum quality standards—as fair.

Two factors heavily influence whether or not consumers view value-based benefit designs—such as reference pricing arrangements and provider tiering—as fair:

- **Freedom to choose.** Consumers view benefit designs that offer several options to choose from more favorably than those that do not.
- **Reassurance that all choices meet a minimum quality standard.** Most consumers are not opposed to benefit designs that steer them toward certain choices, as long as they can be certain they are not exposing themselves to poor-quality care by going to the least expensive options.

Recommendations

Dissemination and Reporting

- **Always convey quality information with cost information.** Presenting quality information next to cost information in a way that sends a strong signal about a provider's performance—such as a word icon²—will help address preconceptions consumers may hold about the relationship between cost and quality that can negatively affect decision-making. In addition, when writing about a provider or treatment's cost, *always* write about the quality as well. This reassures consumers that they are not necessarily exposing themselves to poor-quality care by picking the least expensive option.
- **Focus on reporting costs for “shoppable” conditions or procedures.** Consumers are more likely to use information on cost when they have time and energy to consider their provider and treatment options. Present costs for procedures and conditions that allow consumers time to “shop” (e.g., joint replacement and maternity) rather than those that are urgent or severe (e.g., heart attack).
- **Provide easy access to information emphasizing your organization's independence and expertise, and to the data sources and methods used to calculate the measures.** Include visible, easy-to-access links directly from your report where users can get answers to potential questions they may have about your organization's funding sources and legitimacy and information about the methodology you used to calculate the costs or resource measures.
- **Include contextual language that clearly explains why the information is being presented, how to interpret the information, and what the information says about each provider's care.** Providing proper context will help answer questions consumers may have about the measure, including why it is important, who is responsible for the result (provider, patient, or both) and how to apply the information to their decision-making.
- **Test measures, contextual language, displays, and labels before including them in your reports.** Consumers hold beliefs and information needs that are specific to each measure. Consequently, each measure may require specific language or additional information to address these beliefs and needs adequately and prevent its misuse. Testing is the best way to identify these beliefs and needs so you can tailor your reporting strategy appropriately.

Stakeholder Engagement

- **Educate consumers that intensity of treatment drives up costs, unnecessary treatment can be not only wasteful but also harmful, and that high-quality care can be obtained at a reasonable cost.** Educate consumers so they are able to see why cost, in addition to quality, should be a consideration when selecting a treatment or provider.
- **Work with self-insured employers and insurers to facilitate access for consumers to information on out-of-pocket costs.** Services such as Castlight Health³ offer solutions that provide consumers access to information on out-of-pocket costs—the type of cost information consumers care most about.
- **Work closely with employers that offer high-deductible plans to implement benefit and network designs that provide significant financial incentives to consumers for choosing more efficient care and communicate to consumers that the purpose of the designs is not purely to lower costs, but also to promote good-quality care at lower costs.** Help plans and employers in their efforts to get consumers to identify high-quality, low-cost providers by making sure benefit designs offer several options and include quality information and contextual language so consumers understand why the information is being provided and gain confidence they are not sacrificing quality when choosing a low-cost provider.

Appendix: Methods

AIR conducted eight focus groups with consumers over two rounds of testing.

The first round involved four groups in Baltimore, MD. All participants were enrolled in traditional (HMO/PPO) insurance plans. Two groups consisted entirely of participants with chronic conditions, while the other two consisted of healthy participants.

The second round of four groups took place a month later in Raleigh, NC. All participants were enrolled in high-deductible (HDHP/CDHP) insurance plans. The health profile of the two groups was the same as those in the first round.

Across all eight groups, AIR recruited for participants between 18 and 64 years old and a mix of race, gender, education, income, and ethnicity.

Focus group moderators followed a structured protocol and presented stimulus materials to elicit reactions from participants. The proceedings from all eight groups were transcribed and coded and then analyzed using NVivo software to identify key themes.

¹ Carman KL, Maurer M, Yegian JM, et al. "Evidence That Consumers Are Skeptical About Evidence-Based Health Care." *Health Affairs*, 29(7): 1400-1406, July 2010.

² Please see report titled, "How To Display Comparative Performance Information People Can Understand and Use" for more information on this type of display (<http://forces4quality.org/af4q/download-document/2557/196>).

³ <http://www.castlighthealth.com/>