

## Will Consumerism Rein in Healthcare Costs? Why the Answer Is No

In the first of our multipart *Executive Insights* series on consumerism in healthcare, L.E.K. Consulting examines why a more engaged consumer — despite the increasing optimism — will not be nearly enough to bend the healthcare cost curve or even stop the rising rates substantially.

Later in the series, we will explore what this means for employers, managed care organizations (MCOs) and providers.

U.S. healthcare is nearly twice as expensive per person as it is for other developed countries — and the treatment outcomes are worse. In 1960, healthcare represented 5% of U.S. GDP; now it exceeds 18%, or \$3.2 trillion annually. In 1960, total healthcare cost per person was \$147. Had this cost increased at the same growth rate as GDP, the amount would now be \$1,100 per person. Instead, it is close to \$10,000. Germans pay only about \$4,000 per capita, despite a much older population that smokes at twice the rate, drinks (alcohol) 50% more and is closing in on American obesity rates.

To put this in perspective, the average price of a new car in 1960 was \$2,600. If the price of cars had increased at the same rate as healthcare has, a new car would cost \$180,000 today. For a car that expensive, you would expect an extraordinary machine and unparalleled customer service. Instead, healthcare quality in the United States is mediocre at best. According to a recent Commonwealth Fund report on healthcare systems, the U.S. ranked last overall among the richest 11 nations on measures

of health outcomes, quality and efficiency.<sup>1</sup> Forty-five percent of patients receive the wrong diagnosis, 25% receive an inappropriate prescription and nearly 20% of hospital patients are readmitted for the same condition within 30 days.

The usual scapegoats for the outsized cost are Big Pharma, insurance companies and excess litigation. Actually, prescription drugs represent only 9% of total healthcare costs. Insurance company profits plus overhead are only an additional

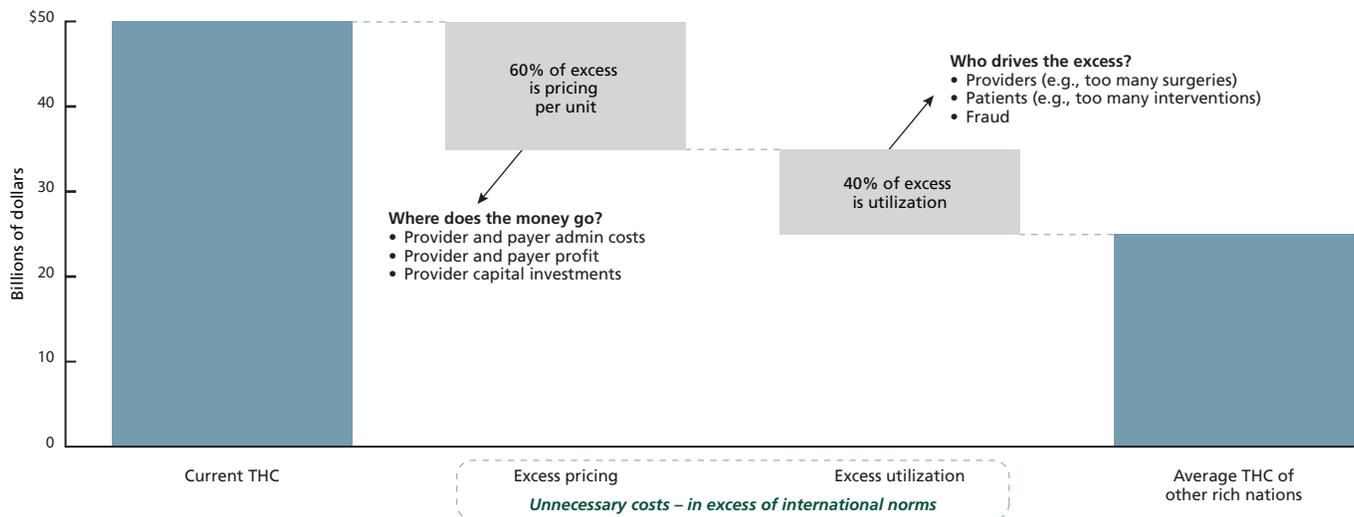
### *Americans pay too much for too little.*

3% of the total \$3.2 trillion spent on U.S. healthcare. Litigation is overrated as a root cause of the cost problem. In truth, the excess cost is driven primarily by high-priced and often unnecessary procedures performed by specialists in expensive settings. In short, approximately 60% of the gap is excess price and 40% is overutilization — too much per procedure for too many procedures (see Figure 1).

*Will Consumerism Rein in Healthcare Costs? Why the Answer Is No* was written by **Wiley Bell** and **Kevin Grabenstatter**, managing directors in L.E.K. Consulting's Healthcare Services practice. Wiley is based in New York and Kevin is based in San Francisco. For more information, please contact [healthcare@lek.com](mailto:healthcare@lek.com).

**Figure 1**  
**Large U.S. Metro – Total Healthcare Costs (THC)**

*U.S. healthcare costs twice as much as in any other rich nation due in large part to excess price and overutilization*



Source: Values are as of 2010; CMS, National Health Expenditures database 2013; OECD Health Data 2011; WHO global health expenditure database; Eliminating Waste in U.S. Health Care, JAMA, 2012; L.E.K. analysis

The pricing problem is proven to be much worse in the commercial market than in Medicare.<sup>2</sup>

## It's Even Worse for Employers and Employees

Employers in the U.S. spend three times more per employee for healthcare than in other wealthy countries. (The roughly 50% of total U.S. healthcare cost represented by Medicare and Medicaid is more closely in line with other countries, although still higher.) The cost for healthcare coverage purchased through employers has increased nearly threefold since 2000, and the employee's share of this financial responsibility is steadily increasing. The percentage of covered workers falling under high-deductible health plans has grown from only 4% in 2006 to 24% in 2015. In addition, the average annual deductible for covered workers has risen from around \$600 in 2006 to more than \$1,300 in 2015. Employers and employees are subsidizing the entire system. Even worse, this increased healthcare cost burden is a major cause of the much-discussed decline in real wages (see Figure 2).

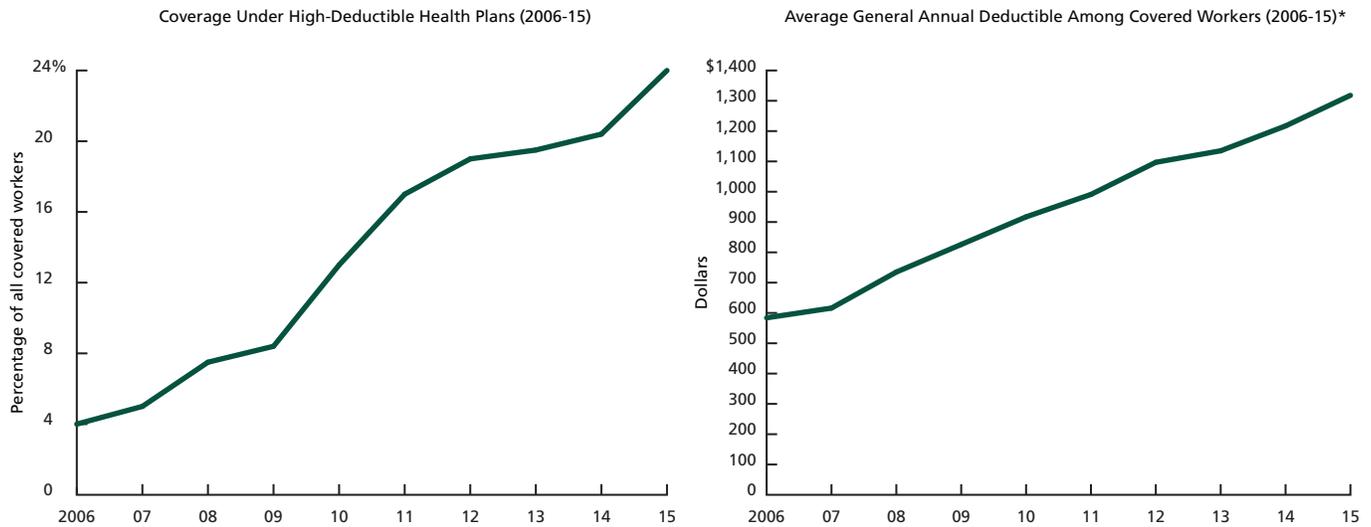
## Consumerism to the Rescue?

Many like to paint a rosy picture of an increasingly consumer-driven healthcare system that looks like this: Employees

(consumers) continue to absorb a greater share of medical expense, which provides an incentive to shop around. Better information about price allows consumers to make informed choices based on personal preferences such as price sensitivity, convenience and brand affinity. Retail-like healthcare (e.g., urgent care centers) gives consumers more options, and the exchanges create a marketplace that facilitates better choices among insurance plans. All this supposedly puts the consumer at the center of healthcare, leading to more competition and increased affordability.

Yes, consumers have become more focused on their health, more concerned about cost and generally better informed. Certainly, many providers and payers are improving customer service. However, consumers cannot bend the healthcare cost curve by themselves. Hospital meals may improve, and doctors' offices may have friendlier receptionists, but consumers will not be in a better position to apply pressure on prices and quality simply because they now pay a larger part of the bill directly out of their pockets.

**Figure 2**  
Employees' Share of Their Healthcare Costs Continues to Grow



Note: Single coverage; among those who face a deductible  
Source: Kaiser Family Foundation

A simple example illustrates why the incentives are incomplete at best, and why the balance of power will still favor providers.

- *Joe, who has a high-deductible health plan through his employer, discovers at the beginning of the year that he has a heart condition. His cardiologist orders a number of tests and recommends surgery. The tests alone use up Joe's \$2,000 deductible, so he is now covered 100% by his plan and has no incentive to shop for the best price for the surgery. With limited and often baffling information on quality and service, and because virtually every hospital in the area is in Joe's network, he is likely to base his choice of hospital on brand image, which is almost always associated with higher cost. So Joe opts for the most expensive option — the university hospital.*

What Joe doesn't know — and neither does his employer or his primary care provider — is that the same procedure at a nearby regional hospital results in better outcomes at half the price. That information is hidden from the marketplace, and even today's "transparency solutions" engender limited trust in the data. No transparency solution on the market today has proven to prevent this issue.

Recent research bears out this dynamic:

- *"Patients travel long distances to access care at Johns Hopkins. The organization's research indicates that just 13% of consumers who travel to receive specialty care conduct factual research during the decision-making process. Instead, emotion drives many care decisions, as do family or friends' recommendations and magazine rankings."<sup>3</sup>*
- *"Increased consumer responsibility for healthcare cost does not increase the likelihood they (patient) will consider cost or shop around."<sup>4</sup>*

Further, a recent study by the Health Care Cost Institute (HCCI) estimates that out-of-pocket costs on so-called "shoppable services" — that is, where a consumer might be reasonably expected to have the ability to comparison shop in advance — represent just 7% of total health care spending. The other 93% of health care costs are not subject to the normal laws of consumer-driven pricing pressure.<sup>5</sup>

## Getting to Root Causes: Six Reasons Why Consumerism Falls Short

The cost problem has been building for decades. Consumers were taken out as direct-paying participants years ago when employers began providing healthcare as a benefit. The third-party payer system was thus born. In other countries, where the third-party payer is almost exclusively the government, there is a budgeted cap on spending per person, so the system is immune to the capitalist laws of supply and demand. The U.S. has designed a uniquely ineffective private/government sector hybrid that has been favorable to supply-constrained providers, most notably specialists. There exists no true price elasticity because high prices are invisibly absorbed by lower wages.

Six fundamental aspects of U.S. employer-based healthcare prevent even an “empowered” consumer from having a material impact on cost.

1. **Plan design.** High deductibles make consumers more price-savvy — until they meet their deductible. After that, when it can really get expensive (for example, a knee replacement or heart surgery), consumers will choose prestige (brand).
2. **Third-party system.** The price of healthcare cannot function as a true signal, as most healthcare expenses are still paid by third parties (employer plan, government). Though ultimately consumers pay for all this through taxes and lower take-home pay, this cost is largely concealed from them — especially when it matters most.
3. **Price and outcome obfuscation.** Even consumers who have an incentive to research expensive procedures find it very difficult to successfully parse the total cost of care or expected quality for any major care episode.
4. **Urgency factor.** Patients undergo a significant amount of stress when they are facing the most expensive healthcare events. As a result, the tendency is to simply go to the biggest, closest and most well-known hospital.
5. **Experts.** Almost always, advice on what to do and from whom to obtain treatment comes from the same experts who are being paid for the service (i.e., providers have misaligned interests).
6. **Image barrier.** Year in and year out, doctors are considered the most trustworthy profession. We want to believe this. The image of expensive hospital systems is similar. But this makes it difficult to attack the core problem: too many procedures at unnecessarily high prices.

While providers didn't create these barriers, they are the central beneficiaries. Expecting the consumer to drive substantial change is naïve. Why would well-paid, well-respected providers want to do anything but resist widespread changes that work against their interests?

## Four Scenarios to Consider

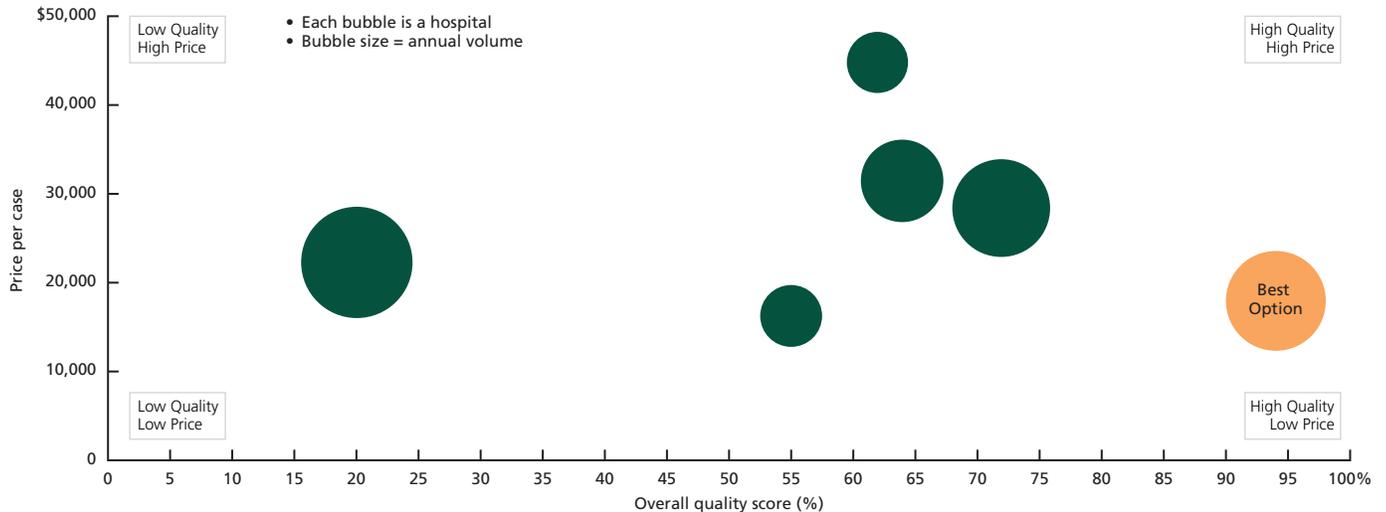
While healthcare costs are already multiples too high, and forecast to inflate, we don't think this needs to be the case. There are four scenarios that could bring the U.S. employer healthcare market more in line with those of most other industrialized countries.

1. Institute a single-payer, government-run system to accommodate employee benefits
2. Push full financial responsibility onto the employee, with consumers empowered and able to make informed decisions about their care in a value-based model — with no intermediaries. (In other words, employers would treat healthcare the way they do housing or transportation for employees.)
3. Help employers take over their healthcare “supply chain” by getting much more involved in designing and overseeing the delivery of care
4. Have MCOs take a much more aggressive stance toward implementing low-cost networks

Figure 3

## Current Cost and Quality Distribution in U.S. Metro Areas for Cardiac Surgeries

Across metropolitan statistical areas and specialties, there is no correlation between quality, volume and cost



Note: Quality score is a composite of rates including core process measures, patient safety, inpatient quality, mortality, complications, readmissions and patient satisfaction.  
Source: Medicare data, Comparison Medical Analytics, L.E.K. analysis

The first option is politically unlikely, although the government has already proven it can drive lower costs and better outcomes. The second option would cause a revolt of a different kind. Employees have become accustomed to healthcare as a benefit; it would be difficult to reverse that long-standing expectation. The third option, with employers taking the lead, is already happening (in part) with dozens of large, proactive employers (e.g., Boeing, Walmart). But most employers are too small to pull this off by themselves. The fourth option, MCOs driving lower cost, would work best in concert with option 3.

The good news: The U.S. doesn't need to replicate socialized healthcare, replacing high cost with long lines and creating a political firestorm. Options 3 and 4 are both viable, in fact complementary. Both rest on the following facts:

1. Low-cost/good-quality provider options exist across the U.S. (see Figure 3)
2. Lower-cost pockets exist even at high-cost institutions; for example, Medicare Advantage has negotiated medical costs one-third less than what the average employer pays

3. Success stories among proactive and innovative employers are rapidly accumulating
4. MCOs are fully capable of playing a major role in developing and accelerating the use of much lower-cost networks

Both employers and MCOs must become significantly more involved in real solutions instead of reworking the old ones and simply shifting more and more to the employee. In turn, employees need to be actively involved — willing to make real choices and expecting something in return for making these choices.

None of this can be done without providers at the table. A new model of good care at lower cost must be fulfilled by medical professionals.

The challenge is how to jump-start a new level of competitiveness in a framework currently dominated by high-price providers, who will understandably be resistant to change. The key is to encourage lower-price providers to take advantage of this rather than emulate their high-priced peers.

The next installments in this *Executive Insights* series on consumerism in healthcare will discuss how employers, MCOs and select providers can do for consumers what consumers cannot do for themselves.

<sup>1</sup>"Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally," *The Commonwealth Fund*, Jun. 2014.

<sup>2</sup>"The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," Zack Cooper (Yale University) Stuart Craig (University of Pennsylvania), Martin Gaynor (Carnegie Mellon University, University of Bristol, and NBER), John Van Reenen (Centre for Economic Performance, LSE and NBER), Dec. 2015.

<sup>3</sup>"What Providers Need to Know About Healthcare Consumerism," *EMS World*," Aug. 26, 2015.

<sup>4</sup>"Even With 'Skin in the Game,' Health Care Shoppers Are Not More Savvy," *Kaiser Health News*, January 19, 2016.

<sup>5</sup>"Spending on Shoppable Services in Healthcare," *Healthcare Cost Institute*, Issue Brief #11, Mar. 2016.

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