Shopping for healthcare isn't the same as buying a car

By David Levine | October 18, 2016

In today's healthcare marketplace, it's common to think of patients as consumers. But is purchasing healthcare the same as buying a car? Not at all, says Amitabh Chandra, a healthcare economist and the Director of Health Policy Research at the Harvard Kennedy School of Government.

"In healthcare, the consumer is sick, tired, confused, distracted," Chandra said in a 2015 interview with Forbes. "Making them deal with a high-deductible plan is double jeopardy: first, they get hit with an illness. And then we hit them financially and cognitively. It's not fair. And it doesn't work."

athenaInsight spoke with Chandra about the real effects of high deductibles, pharmacy copayments, and other tools designed to increase patients' "skin in the game" — and about some unconventional ideas for keeping patients engaged in their own health.

Q What is the focus of your work?

A At a high level, I am interested in driving down the cost of healthcare, but in ways that protect patients and the quality of care. There are basically two sets of tools at your disposal to do that. There are supply-side tools such as capitation, accountable care organizations and bundled payments. At the same time, there are demand-side tools. My research is on what actually works to drive down costs.

Q Based on your research, is it realistic to think of patients as consumers?

A Yes, but it has to be developed in completely different dimensions. How do we create a product where the patient has the right incentives to pick the right plan at a time when they are healthy? So that when they are sick they are not hit with additional copays and deductibles? The industry should engage patients once a year — who is your doctor and your affiliated hospital — and then that's it. There should be no additional shopping to be done, no additional price comparisons to be done.

The second takeaway is we need to think harder about adherence. If there is no adherence, it is like not having a drug developed in the first place.

Q How are efforts to drive patient behavior working so far?

A Demand-side tools at our disposal include high-deductible plans, copayments, and price transparency. My research is on what you actually get with these tools. The answer is, not much. We should engage patients in ways that go beyond these crude cost-sharing devices.

Q What should we be doing instead?

A My work shows that even small increases in copays — say, from $1 to $5 — discourages patients who are chronically sick with high blood pressure, high cholesterol, diabetes, these types of chronic illnesses, from picking up drugs. And they end up in the hospital from not taking their drugs. So you didn't save money at all. You reduce demand, but in a very haphazard manner.

Which raises the question: Why have copays on drugs that work? Have you ever met a patient who overuses their diabetes drugs? If anything, there should be a negative copayment — pay them to take the drug to keep them out of the hospital.

Q What about those high-deductible plans that have become so commonplace?

A There is no question that employees who use high-deductible plans spend less and are healthier. But that may be because they are typically younger, healthier individuals who choose these types of plans. So we looked at a large self-insured company that moved everyone to a high-deductible plan. People didn't have a choice.

We saw that this plan certainly does save money — between 12 to 15 percent, which is a lot of money in healthcare spending. On the other hand, we noticed that people were not shopping for cheaper care. Not even a little bit. They cut back haphazardly on things like prevention, imaging and emergency room use — all to the same extent, when you would have thought they would cut back more on just imaging.

Q So how did the plan generate those savings?

A The savings came from very sick people who cut back even though they were over the deductible, which makes no sense. If you are sick, that's when healthcare insurance works for you, and you should not be cutting back. Which means people don't understand the concept of high-deductible plans.

Q What is your bottom-line impression, then, on consumer-directed care?

A It needs to be fixed. What we are currently trying is not working. We need to think about using prices in an easier way for people to understand.

At the end of the day, we are always trying to do new things in healthcare. There are so many problems, and we are always drawn to new solutions to old problems. I have begun to wonder if maybe the old solutions were better.

Q Which old solutions, specifically?

A For instance, using antitrust laws to break up the big hospitals. We know that [antitrust] works but we have passed on that. Maybe the right answer was that we don't need behemoth hospitals. Then you don't need things like pricing transparency. It has brought me full circle on thinking about antitrust policy in healthcare, especially in care delivered by hospitals, which is still 40 to 50 percent of care.

David Levine is a writer based in Albany, N.Y. This interview was edited and condensed.

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