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Meeting Employees' Information Needs in an Evolving Health Care Marketplace

***Overview**—This background paper explores the role of information in an evolving health care marketplace. As the economy continues to soften, many employers are seeking relief from escalating health care expenses by shifting costs onto employees. Some are trying to make their retreat more palatable by offering employees both more options for how and where they receive health care and more control over how and where the money is spent. This paper discusses how the decisions people make are likely to change over the next decade, what this means for their information needs, whether data are available to meet those needs, and what may have to happen to ensure that people have the information they need in a usable form when they need it.*

After several years of low to moderate increases in health care costs, employers are seeing a return to high growth rates reminiscent of the late 1980s and early 1990s—a time when escalating costs resulted in major changes in the delivery, financing, and management of care. Monthly premiums for employer-sponsored health insurance rose an average of 11 percent in 2001, versus 8.3 percent in 2000 and 4.8 percent in 1999. Similarly, the rate of increase for self-insured employers rose from 7.1 percent in 2000 to 9.5 percent in 2001. For small purchasers with fewer than 200 employees, the increases have been even more dramatic.¹ Moreover, recent surveys indicate that the average cost of health benefits will be at least 13 percent higher in 2002, with a significant number of employers seeing an increase in excess of 20 percent.² Many industry experts expect that this surge in costs will slowly but surely bring about another series of changes that could have major implications for those Americans receiving coverage through the nation's employment-based system.

THE NEW AGE OF CONSUMERS

Chief among the expected changes is a growing emphasis on “consumerism”—an evocative term that implies a returning of power and control to the actual consumers of health care services, rather than the employers that pay for care or the health plans that deliver it. Frustrated with the current system and increasingly knowledgeable about its limitations, many Americans have been demanding a larger role in making decisions about their health care. Until recently, however, employers were reluctant to make changes and offer choices that could add to their costs.

But now, concerned about escalating costs, employees' growing dissatisfaction with their health care options, and the potential for legal liability, employers and their consultants are developing strategies to control their expenses by offering more choices and encouraging employees to become active, involved health care consumers. Many purchasers see consumerism as an opportunity to shift accountability and financial responsibility for health care from themselves to employees and their families. The Washington Business Group on Health recently reported that 71 percent of surveyed employers plan to pass on the increase in premiums to employees, and only 52 percent will absorb at least some of the increase themselves.³ And in a survey of employers conducted by the consulting firm Towers Perrin, 83 percent of respondents indicated an interest in using consumerism as a tool for controlling costs.⁴ While there are many ways in which this can happen, the bottom line is that a large number of privately insured people will soon bear more of the financial burden for the health care services they consume.

By shifting financial responsibility and expanding choices, consumerism is seen as a way both to help employers manage their costs and to enable employees to make better decisions for themselves and their families with respect to health plans, providers, and treatments. Moreover, the expectation is that “empowered consumers” who feel the impact of their decisions will be motivated to make choices that maximize value—that is, the quality of care they get for the money they spend. At a societal level, this effort to develop a stronger role for consumers represents an

BACKGROUND PAPER

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attempt to succeed where managed care and employer clout have failed: proponents of this market-oriented approach are hoping that informed consumers with true purchasing power will finally compel the health care system to meet their needs for affordability, access, and high quality.

Anticipated changes in public policy may also give people without employer-based coverage the opportunity to make decisions they have not had to make before. At the same time that employers are creating a larger role for insured workers in coverage decisions, policymakers are looking at ways to provide coverage for the uninsured, many of whom are employed.⁵ President Bush as well as members of both parties in the House and Senate have proposed financial incentives, in the form of tax credits, tax deductions, or vouchers, to encourage those without insurance to get coverage. Policymakers considering these proposals are faced with making two determinations critical to their success: (a) whether the infrastructure of the current system of coverage and care is prepared to meet the needs of these potential consumers and (b) what it will take to ensure that the newly insured have the information and support needed to make good choices. And questions about the availability and adequacy of information will loom even larger if Medicare ever moves to a more competitive model.

Information: A Critical Commodity

If Americans are to assume more responsibility for their health care, they will need to be equipped with reliable, comparable information that will allow them to make the decisions that are best for them and their families. They will also need guidance in using this information effectively and efficiently. In the current system, many people believe that they know what they need to know: a recent survey by the Kaiser Family Foundation and the Agency for Healthcare Research and Quality (KFF/AHRQ) found that the majority of people feel “very or somewhat confident” that they have enough information to make the right choice among doctors (79 percent), hospitals (73 percent), and health plans (67 percent).⁶ And, until they have greater responsibility for their decisions, many employees will probably continue to say this. But with more choices and more at stake, information is expected to become a critical commodity. What data will people need to make their choices of health plans and providers manageable? Are these data available now? Where and how will they get information? Who will develop and disseminate consumer-friendly information? Who will pay for it?

Who will ensure that the data are reliable? And who will support consumers in using this information?

While this background paper focuses on decisions related to health plans and providers, this is not meant to imply that these are the only choices consumers will have to make. As they assume greater risk for their health care costs, consumers are also very likely to become more involved in comparing the costs, effectiveness, and quality of different treatment options. Their desire to have greater input into the clinical decision-making process is likely to have huge implications for the amount of information people will need and the ways in which they receive and use it.

HOW CHOICES ARE EVOLVING

The information consumers need is a function of the choices they have to make. The limited realm of choices employed Americans have today stands in stark contrast to the wealth of options they may have in the not-so-distant future.

Today’s Choices

For Some, a Choice of Plans. A survey of employers sponsored by the Kaiser Family Foundation and the Health Research and Education Trust found that nearly two-thirds of Americans have access to employer-based coverage and that 65 percent of that group have a choice of more than one health plan.⁷ There may be some discrepancy between what employers report and what their employees perceive: in a recent survey of people with employer-based coverage (also sponsored in part by the Kaiser Family Foundation), only 55 percent of respondents reported that they have a choice of health plans.⁸ While this could be a function of different survey methodologies or statistical error, it is possible that some people are not aware of the choices they have or that employees disregard or discount choices that are not realistic options for them.

For Most, a Circumscribed Choice of Providers. While the percentage of workers enrolled in traditional indemnity plans has fallen considerably over the past 10 to 15 years, dropping from 73 percent in 1988 to 7 percent in 2001, a substantial segment of the employed population (48 percent) gets coverage through preferred provider organizations (PPOs), which allow enrollees to choose from a fairly wide network of providers who have agreed to discounted rates. (This segment has also been growing, from 28 percent of enrollees in 1996 to 41 percent in 2000 and 48 percent in 2001.) The 23

percent of workers enrolled in health maintenance organizations, or HMOs, have a narrower array of providers to choose from; most of these plans are fairly restrictive, but some have expanded their panels in the past few years to appease employers and members. The remaining 22 percent of workers who choose point-of-service, or POS, plans also have narrow panels of providers, but with the option of paying more to see providers outside of the network.

What this means is that less than half of workers and their families are limited to the set of providers selected by their health plan. PPO enrollees have more options, although they also have strong financial incentives to choose those providers associated with the plan. Thus, while most people can exercise some choice over the providers they see,⁹ they are still making their selections from a set determined by their health plan or, in a handful of cases, their employer (while very few self-insured employers contract with providers directly, some belong to purchaser coalitions that contract with their own network of providers).

Looking Ahead: More Costs, More Choices

While it is always tricky to predict the future, there is broad agreement that the current system is not sustainable. Consumers are increasingly dissatisfied with restrictions on providers and treatments, providers and plans are frustrated in their efforts to serve multiple masters, and purchasers are between a rock and a hard place—paying higher and higher prices just to get complaints from both sides.

As noted earlier, the most likely change is that employers will begin shifting more of the costs of care and coverage onto consumers. The cost-shifting model getting the most attention at this time is the defined contribution strategy, in which employers give employees a set amount of money towards health care coverage and services. This strategy shifts the risk of decisions away from employers and onto employees, who would have to pay for expenses that exceed the fixed contribution. Industry experts anticipate that most of the employers that take this route will maintain a presence in the health care market by identifying and providing access to different coverage options but will have a smaller stake in the choices that people make. At an extreme, employers could even remove themselves entirely from the picture by handing employees extra cash to use in the individual market, but that is not regarded as a likely scenario at this time, primarily because the individual market is considerably more expensive and subject to medical underwriting. To date, few purchasers have

pursued a defined contribution strategy, and those that have done so tend to be smaller businesses eager for ways to manage their expenses and offer coverage they could not otherwise afford. But surveys indicate an increasing interest in these models—interest that may grow if the economy continues to weaken.

One of the potential benefits of a defined contribution strategy is that it liberates employers to make a variety of health care coverage options available to workers, including new models that encourage provider organizations to compete for business and be more accountable to consumers. If adopted widely, this strategy could make the health care system behave more like other markets, where the emphasis is on identifying and meeting the needs and interests of consumers. But that will only happen, observers believe, if consumers have access to information that allows them to determine who can serve them best.

HEALTH CARE INFORMATION: WHAT CONSUMERS WANT VERSUS WHAT IS AVAILABLE

Information is the linchpin of a consumer-oriented model: without information, people cannot behave like true consumers, that is, they cannot make decisions that reflect an understanding of their options. To the extent that consumers find themselves in an environment where they must exercise choice and take greater responsibility for the choices they make, information is likely to play a much greater role than it has in the past.

It is important to note, however, that different kinds of consumers have different needs for information. The needs of those with employment-based coverage may not be the same as those covered by Medicare, Medicaid, or other programs or the same as workers without insurance. Moreover, the segment with private coverage is not at all homogeneous—there is wide variation in the kinds of information that people in this segment want, as well as in the ways they prefer to receive communications. One of the challenges of the next decade will be to move away from a “one-size-fits-all” approach to developing and delivering information to one that can be customized or personalized to meet the needs of specific consumers or groups of consumers.

Information Needed to Choose Health Plans

As noted above, close to two-thirds of people with coverage from their employers currently have a choice of health plans, and a growing number of employers are expected to expand the number of options they offer.

What information will consumers need to choose a good health plan?

First, they need better information on costs, coverage, and the “ground rules” that define how different plans operate (for example, how enrollees get to see specialists, how they appeal coverage decisions). While this kind of information has been available, it has not always been delivered in a form that consumers can easily understand and use. As more choices become available, it will become increasingly important that consumers have access to tools that allow them to use this information to compare options and make informed decisions.

To make a truly informed decision, however, employees also need to know about the quality of care they can expect from different plans. Over the past ten years or so, a variety of private and public organizations, including many employers, have tried to help people be more effective consumers by providing them with information about the quality of competing health care organizations. In most cases, this information takes the form of “report cards” that show the performance of health plans across a range of standardized measures.

Many health policy analysts agree that it is too soon to judge the effectiveness of these comparative reports in terms of their ability to help consumers make sound decisions. One issue is awareness: according to a recent survey, only 23 percent of Americans have seen information comparing the quality of health plans.¹⁰ Another obstacle is relevance. For the many employed Americans who do not have a choice of health plans, comparative reports have no value because there is no decision to make.

Do these quality reports have value for those people who see them and have choices to make? The jury is still out. On the one hand, respondents to a recent poll on this topic say that quality is very important: when asked about their biggest concern in choosing a health plan, consumers say that quality of care is more important than low cost, wide range of benefits, and wide range of doctors. Moreover, a substantial majority of those who have seen comparisons of quality say that the information would be useful. But on average, only 9 percent of those who saw reports on health plan quality actually used it to help make a decision. Of those who did not use the information, nearly 40 percent reported that other factors, such as cost and location, were more important.¹¹

One interpretation of this apparent contradiction between consumers’ actions and their words is that people are trying to strike a balance among all of their concerns. Quality reports provide only a piece of the

puzzle, and often one that is hard to fit into the bigger picture. Another possible explanation is that people may not be sure what they mean by quality, or they may use definitions of quality or value that are different from those offered in a standardized report.

Assuming that employed consumers soon have more choices and that those choices are primarily health plans, it is not likely that “report cards” in their current form will be sufficient to meet consumers’ information needs. First, the content of health plan quality reports would have to become more accessible and usable for consumers; one-quarter of those who saw a report say that they did not use the information because it was confusing or difficult to understand.¹² Second, while there is certainly a role for information on quality, these reports would have to be supplemented with data that capture the other factors that influence decisions, including costs, accessibility, and rules. One of the biggest challenges will be to develop tools that help consumers sift through all these different pieces of information to find the ones that matter most to their decisions. Although reports intended to help consumers have been around for a while, the creation of information on health plans that really meets their needs is still in the early stages.

Information Needed to Choose Providers

Of course, one of the biggest drawbacks to health plan report cards is that they do not capture the level of the health care system that appears to be of greatest interest to consumers. Although some people feel strongly about their particular health plan, most do not see the decision as being as consequential as their choice of a provider. Even if they understand that health plans can affect the quality of care they receive, they tend to be more concerned about the quality and other characteristics of the providers that treat them. And with few exceptions, those who cannot choose their plans can still exercise some discretion over their providers.

In a scenario where employers shift responsibility for both costs and decision-making to consumers, many industry experts anticipate that consumers will want a greater say in selecting their providers and that at least some consumers will be given the opportunity to bypass today’s health plans. In fact, a handful of new companies—including Vivius, Sageo (sponsored by the benefit consulting firm Hewitt Associates), and Definity Health—are betting their future on the demand for a more direct relationship between consumers and their providers. For this “retail” approach to succeed, consumers will have to have some way to discriminate among their options.

Over the past decade, both public and private organizations have released comparative cost and quality information on hospitals and physicians. Because of statistical limitations, information about physicians is nearly always focused on medical groups rather than individual doctors. In California, for example, the Pacific Business Group on Health sponsors a survey-based report on the performance of physician groups across the state; a few health plans, including PacifiCare in California, also issue quality reports on the medical groups with which they contract. However, this kind of information has not always found much of an audience among the public. (On the other hand, the information has often been useful for health plans, employers, and the providers themselves.) In some cases, a lack of awareness and easy availability diluted the usefulness of the information; in a recent survey, for example, only 15 percent of respondents indicated that they saw comparative information on hospitals in the past year, and only nine percent saw information on physicians.¹³ But many of these reports had a larger problem in that the material simply did not speak to the concerns and interests of consumers.

What are those concerns? First, to the extent that they actually bear the expense of health care services, people will want to know about costs. With the exception of services that are typically paid for out-of-pocket (for example, laser vision correction), little information on prices is easily available now. However, there are already a number of companies on the Internet where consumers can compare providers who submit prices for certain medical procedures and health care services. These sites are designed to serve people who have to be conscious of the expense of health care, perhaps because they lack coverage or because they pay coinsurance for the service after meeting their deductible. Other visitors likely include those seeking discretionary procedures that are typically excluded from coverage (such as cosmetic surgery) or treatment for which they have limited coverage, like alternative health services.¹⁴ As more people become responsible for paying health care bills, the demand for information on the prices of common provider services is likely to grow.

To assess the relative value of those services, consumers will also want to know more about the quality of providers. When asked how they would evaluate the quality of a provider, respondents to the Kaiser Family Foundation's survey expressed a strong interest in knowing about the experience of the provider (for example, how many times a doctor has done a

specific medical procedure, how much experience the hospital has in performing a particular test or surgery). They also wanted to know about the qualifications of providers and the perceptions of their patients. However, respondents placed the greatest emphasis on information that could help them avoid being harmed, such as data on malpractice suits and medical error reports.¹⁵ Focus groups and a consumer survey sponsored by the California HealthCare Foundation (CHCF) support these findings: in addition to wanting information on physicians' communication skills and qualifications, many consumers expressed an interest in data on complaints and malpractice suits.¹⁶ The interest in mistakes and safety problems probably reflects the effectiveness with which the media have communicated the findings of the Institute of Medicine's recent report on medical errors, but it also suggests that the potential to avoid or at least minimize the chances of a negative experience resonates with consumers.¹⁷

How much of what people want to know about provider quality is available now? The answer is mixed. There are numerous sources of data on physicians' credentials (for example, education and board certification), as well as other basic information, such as hospital privileges and licensure status. Some health plans and independent organizations are also making available information on patients' satisfaction with physicians' communication abilities and office staff; while most conduct their own surveys, there is a growing movement to use standardized surveys that allow for local, regional, and even national comparisons.¹⁸ Less common are measures intended to capture clinical quality. For primary care physicians, for example, these measures may indicate whether the physician is administering important preventive services appropriately. For specialists, the measures may focus on the volume of procedures they conduct. Many of these quality measures are being adapted from indicators developed to evaluate health plans, so their application to physicians is often subject to debate.

The new companies that are trying to facilitate a direct relationship between employees and their providers are giving consumers as much specific information as the physicians will allow. Information available through Vivius,¹⁹ for example, includes the doctor's educational background and credentials, a description of his or her practice (including office location and hours), and any performance data the doctor wants to post. In addition, Vivius offers access to HealthGrades, a Web site (www.healthgrades.com) that rates the performance and quality of hospitals and physicians nationwide.²⁰

One potentially troubling phenomenon is that many of the Internet-based companies are not measuring or reporting provider quality in a standardized way, but are simply accepting, summarizing, and displaying whatever physicians submit to them. The downside of this approach is that the data consumers see may not be comparable, which will complicate the task of making an informed decision. It also creates the potential for a scenario in which the winners are the physicians who appear best through clever marketing, rather than those who objectively perform the best. On the other hand, there is a potential upside in letting the market function on its own. Representatives of these companies predict that this approach will encourage physicians to become more sensitive to consumers' needs and develop innovative ways of meeting them. For example, in addition to offering summaries of survey data on the satisfaction of patients, physicians might offer qualitative information in the form of patients' comments. Or they may try to show evidence of the high quality of care they provide by documenting improvements in the self-reported health status of their patients.²¹

While there is little standardized information available today to help consumers choose the best providers, information that could help consumers identify the "bad apples" does exist. However, the idea of opening this information to the public is very controversial, primarily because providers worry about presenting the raw data without any context. In particular, they fear that consumers could misinterpret data on malpractice payments if they do not understand that some specialties are more likely to be sued than others and that insurers can settle cases without the doctor's agreement rather than incur the cost of litigation.

Right now, the availability of this kind of data varies widely by state. About one-third of state medical boards offer information that profiles physicians, but many of them do not include malpractice or criminal records. A national database recently developed by the Federation of State Medical Boards also does not include this kind of content.²² The best example of a database on physicians appears to be Massachusetts' Board of Registration in Medicine Physician Profile, which makes data on malpractice payments open to the public. What makes this database so well-accepted is that the information is put in context: in addition to explaining how medical malpractice payments work, the data include the number of physicians in the doctor's specialty, the number of physicians who have made payments in the last ten years, and whether the payment amount was average, above average, or below average for its type.

It certainly seems to be filling a need: between 1997 and 1999, the number of physician profiles requested by consumers in Massachusetts grew from 500,000 to over 2.5 million.²³

The most comprehensive source of this kind of information—including medical malpractice judgments, disciplinary actions, and criminal convictions—is the National Practitioner Data Bank (NPDB), which is not open to the public. The NPDB contains records on about 150,000 health care practitioners, primarily doctors but also dentists and other health care professionals. Only managed care organizations, hospitals, government agencies, and peer-review organizations have access to it, and they are forbidden by law from sharing that information with consumers (unless it can also be obtained from another source). In the last Congress, a bill was introduced by Rep. Thomas J. Bliley Jr. (R-Va.), who has since retired, that would have given the public access to the data in the NPDB.²⁴ However, it is unclear whether this issue will be taken up by the current Congress.²⁵

WHERE AND HOW CONSUMERS GET INFORMATION

Likely changes in the employment-based health care system will clearly have an impact on the kinds of information that people want to have. But that is not the only area in which some changes can be anticipated. Today, one of the biggest challenges for those trying to educate consumers about their options is how to *deliver* that information most effectively and efficiently. That challenge is only likely to become more difficult in the future if the information has to reach even more people with even less in common.

For the purpose of considering this issue, it is useful to differentiate between who conveys the information—sources such as family, employers, the public media, and independent organizations—and the ways in which they can convey it—on paper, electronically (most likely through the Internet), and orally (that is, in person or over the telephone). This distinction provides a way to separate questions of trust and influence from strategic decisions that reflect consumers' behaviors and preferences.

Conveyors of Information

Current Sources: Mixed But Personal Network Predominates. In surveys, consumers report that their health care-related choices would be most influenced by

ratings or recommendations from their doctors and from friends and family. Patient surveys are also influential, as are employers and physician groups such as state medical societies. Government agencies and consumer groups tend to be toward the bottom of the list.²⁶

These findings are often cited as evidence that people do not or will not consider sources of information beyond their personal network. But that interpretation of the data overlooks some factors. First, these sources are not mutually exclusive; people probably consult multiple sources of information, even if just to confirm their impressions or current choices.

Second, what people say they would do can be different from what they actually do. For example, a survey conducted by RAND and the CHCF asked consumers where they get health information to compare different doctors, hospitals, and health plans. While no source received a large number of responses, respondents cited newspapers, magazines, and television more than other sources (except when asked about physicians, for whom “friends/relatives/co-workers” remain the primary source).²⁷ With some notable exceptions (such as *US News and World Report* and *Consumer Reports*), data in the public media are likely to originate with state agencies, consumer groups, or employer groups, which suggests that people may be more influenced by these sources than they realize.

One thing that is not clear is whether the level of influence associated with different sources is a matter of trust, personal relevance, or, more likely, both. For example, the RAND/CHCF survey suggests that consumers trust doctors most, followed by voluntary disease-focused organizations and friends and family. The KFF/AHRQ survey does not ask specifically about trust, but a substantial majority of respondents indicated that they would be “very likely” to seek information about quality by asking people they know and presumably trust (that is, friends, family members, co-workers, and health professionals).

With the exception of the voluntary organizations, this personal network also represents the sources most likely and best able to provide information that is customized to the needs of the person seeking the information. One common criticism of information from other sources, including employers, government agencies, and consumer groups, is that the information they provide is too general and impersonal. People do not know how to apply it to their own circumstances. It is not surprising that consumers would prefer sources who can provide them with only the information they

can use when they actually need it, and can even help them use it.

Likely Changes. Experts in the field of consumer information anticipate significant changes in the delivery of comparative information on health plans and providers. While friends and family will remain the prevailing source, new sources are likely to arise to complement and add to the anecdotal information consumers rely on. In contrast to today’s institutional sources (such as employers and health plans), which often have a stake in the decisions that people make, these new sources are expected to be independent and unbiased private companies and nonprofits, such as consumer organizations.

Efforts to make information more personally relevant are also likely. One possibility is that sponsors will try to develop consumer information that can be tailored to different segments of the population. For example, using computers, consumers could get information that is suitable for their demographics and health status (for example, a young adult female with an asthmatic son could first see comparative information related to pediatric care, chronic care, and gynecological care). Another similar option is to offer decision support tools that help guide consumers through the available information to make the choice that suits them best. For instance, a decision support tool could identify providers that meet specific preferences elicited from the consumer. To help federal employees choose among the many health plans available to them, the U.S. Office of Personnel Management offers access to this kind of tool through its Web site. A third option is to create an ombudsman program, which puts a human face on the delivery and use of cold statistical data. Using hotlines and face-to-face contact, some organizations may offer an intermediary who can personally help consumers identify and assess their options. Tactics like these would enable organizations to get closer to providing the kind of personal touch that many consumers seek.

The role of government agencies and employers—the two biggest producers and disseminators of comparative information today—is also likely to evolve. Consumers appear to support government involvement in this area. Over 60 percent of survey respondents believe that the government should be promoting, monitoring, or providing information about the quality of providers and plans. And nearly three-quarters believe that the “government should require health care providers to report all serious medical errors to make sure this information is publicly available.”²⁸ Experts on consumer information argue that the collection of

information is an appropriate role for government agencies. However, these agencies do not have the expertise to make information appealing. The job of distributing information in a usable form will likely fall to media, business groups, and others in the private sector who are better suited to packaging that information for various constituencies.²⁹

Consumers are not as clear about their interest in information sponsored by employers. On the one hand, a majority of people currently claim that they do not trust their employers to be objective because they have a financial stake in the decision. But over a quarter report that recommendations and ratings from employers would have “a lot” of influence on their choices of providers and plans.³⁰ Still, employers are the most obvious source of information for employed workers with coverage, and they are likely to continue in this role as a benefit to their employees, either on their own or as part of a business coalition. But the role will change as the purchasing environment changes. For instance, there may be a new dynamic if employers have a smaller stake in the decision and are no longer dictating the options available to employees. Rather than being the ones that are limiting options, some employers may choose to play a welcomed facilitating role, helping employees identify the options that best meet their needs. Others may seize the opportunity to cut back on their involvement in their employees’ health care; for example, they may continue to provide employees with information but not make the investment required to make the information more user-friendly.³¹

As information sources come and go over the next five to ten years, consumers will be faced with a new set of questions and problems. For example, as more sources become available, industry experts are already starting to see the beginnings of a free market for comparative health care information. How will people know which sources to trust? Who will decide who (or what) is a credible source? What will consumers do with conflicting information about the plans and providers with whom they are entrusting their families’ health?

Information Delivery Methods and Media

The question of what method or media to use to deliver comparative information has been perplexing for sponsors. This section reviews the prospects for three options: printed media, electronic information, and oral communications.

The Present and Future Use of Print. The obvious (and most common) answer to the question raised above is to produce and distribute printed text, usually with a

limited distribution (for example, to employees) but occasionally through the mass media. In their survey of California consumers, RAND and the CHCF found that public media (newspaper, magazine, and to a lesser extent, television) were among the most commonly cited sources of information to compare plans and providers. For health plans in particular, consumers also reported seeing brochures or pamphlets from their employers and other sources.³²

But print media have some serious drawbacks. Perhaps the biggest problem is that it is almost impossible to provide all of the information that any consumer might want to see without completely overwhelming the reader. To appeal to potential readers, most written reports aim to be as succinct as possible, which typically requires that they present either summary-level information (so that details are not available to those who want them) or selected measures that meet the needs of some readers but not others. Another flaw of print media is that it is difficult to update. Once something has been printed and distributed, it can be burdensome and costly to amend the data or add new information. Finally, printed media presume that consumers are willing and able to find the information that is relevant to them, interpret it, incorporate it into whatever else they know, and apply it to their circumstances. For many people, that requires an unacceptable level of effort and investment of time; for some, it requires a level of literacy (and numeracy) that they just do not have.³³

Looking ahead to a scenario where at least a segment of employers are no longer limiting health care options, it may no longer make sense for companies (or their benefits consultants) to produce their own comparative information. But it is not clear whether public media—particularly magazines and newspapers—will be able to fill the gap effectively. The dilemma is that consumers seem reluctant to rely on information from the public media. In one national survey, a relatively small percentage of consumers were willing to rely on ratings or recommendations in newspapers or magazines.³⁴ Trust is clearly an issue. While consumers tend to believe *Consumer Reports* magazine, they seem more skeptical about other publications.

That said, the media have played a major role in recent years with respect to making the public more aware of health care issues related to clinical care and quality (particularly medical errors). Experts in the field of quality reporting point out that the public media have expertise at communicating complicated subjects (although some would argue that they do this through oversimplification). Mass media publications also offer

the potential of reaching many more people than can be reached through employer-sponsored initiatives. Millions of people are exposed to magazines and newspapers on a regular basis; in the RAND/CHCF survey, nearly 60 percent of respondents said they read a daily newspaper either a few times a week or every day.³⁵

It is possible that the media could play an even larger role; rather than simply distributing information provided by others, various outlets may start to collect and analyze their own data (much like *US News and World Reports* and *Consumer Reports* do now). To the extent there is a market for this information, comparative data on health care options could become as ubiquitous (and competitive) as information on colleges is now. There may be a risk in having too many people involved in providing competing interpretations of cost, quality, and other information, but that seems preferable to the alternative.

Exploiting the Potential of the Internet. A number of public and private organizations, including the Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration), a handful of business coalitions, and some private companies (for example, HealthGrades.com), are already using the Internet to provide consumers with access to comparative information on plans and providers. The trend toward consumerism is expected to have a substantial effect on use of the Internet for these purposes.

One reason is that, for many people, the Web is easily accessible at home, at work, and through libraries and schools (although not all segments of the population can get online, which raises concerns about equitable access to information). The Internet offers several features that make it particularly useful. Perhaps the most important of these is the ability to customize information to the user. While most current efforts to provide comparative information on the Web simply mirror printed reports, a few are starting to take advantage of the computer's ability to let people see as much or as little as they want to see and to customize information to meet specific criteria and preferences. Over time, these programs are expected to become much more sophisticated and user-friendly.

A related benefit is the potential to offer interactive decision support tools that will help users make the choices that best suit their health care needs and financial constraints. The sheer amount of information that consumers already have to process to make a decision poses a serious cognitive challenge—a challenge that will only grow larger as more information becomes

available about different levels of the health care system. Researchers have found that people find it difficult to weigh and make trade-offs among all the different factors they want to consider. As a result, they tend to take shortcuts, for example, by making decisions based on one or two variables, which can lead to choices that do not really meet their needs. Computer-based decision support tools should be able to overcome some of the cognitive barriers by helping people specify their needs and identify the most suitable options.³⁶

Experienced developers of comparative information believe that its potential is only beginning to be apparent. Used creatively, electronic information may be able to address many of the limitations that have handicapped printed media. For example, by taking advantage of new technologies, sponsors may be able to make comparative information easier to understand and use. At some point, for instance, they could address some of the literacy issues that have kept people from using the information by replacing complicated text with sound and pictures. Information on the Web can also complement print media. Those who develop comparative information may provide enough data on paper to capture consumers' attention, then refer them to the Web for the detail they need for decision-making purposes.

However, while the Internet has huge potential as a medium for delivering comparative information, current data on consumer behavior and preferences raise some doubt about how quickly it will be accepted. Just over half of respondents to the KFF/AHRQ survey said they would be very or somewhat likely to go online to get information on quality.³⁷ But, as with the public print media, trust of Internet Web sites is a major concern. Given a list of 17 potential sources of information, consumers surveyed in California indicated that they trust "Internet Web sites" least of all.³⁸ In the short run, it is likely that consumers will use Internet services to confirm what they already know about plans and providers and what they hear from friends and family or from the media. Over time, as people get more accustomed to getting information off the Internet, they may be more open to using it as a tool for facilitating their decision-making process.

A Continued Role for Personal Assistance. Researchers involved in developing and evaluating communications strategies concur that there will always be a segment of consumers who either cannot or will not use information in either printed or electronic form. This is particularly an issue for those who lack the language, literacy, and other skills necessary to use these materials on their own.³⁹ And even those who use impersonal media may continue to

want someone to talk to about their decisions, whether neighbors or benefits counselors.

However, while the need for access to personal assistance is evident, the solution is not. One option that some sponsors have explored is call centers; CMS, for example, has a toll-free number that Medicare beneficiaries can call for information about their choices. Employers can also offer this kind of help through their human resources staff. But there is likely to be a large gap between the small number of large employers that can afford to provide this kind of help and the many employers that cannot (or are unwilling to do so). This raises some troubling questions about the many consumers who will not be able to interpret and use comparative information without some personal support. Who will help them? Will they be less satisfied with their health care decisions? Will they receive poorer quality care?

SOME IMPLICATIONS

Given the preceding discussion of the types of information that consumers will need, the likely sources of that information, and the ways in which the information can be delivered, what are the key issues that will have to be resolved over the next five to ten years?

Missing Information

Some critical information is missing. First, while consumers now have access to at least some comparative data about health plans and hospitals, they know little about the differences in cost and performance among physicians, which is the level people care about most. Experts in the area of consumer information suggest that a lack of leadership from the physician community is responsible for the lack of progress over the past few years with respect to developing meaningful measures and making them publicly available.⁴⁰ If physicians fail to take ownership of the issue of performance measurement, they may find that entrepreneurs will step in to develop the information and market it to consumers. While the political and methodological obstacles to measuring physicians' performance are significant, industry observers believe that they are not insurmountable.

Second, as the health care market evolves, people will need information on hybrid plans, that is, variations on existing configurations, such as products with high deductibles. For example, the purchasers that offer access to care systems, or integrated delivery systems, provide consumers with ways to compare the

costs and performance of these organizations. But consumers will also need ways to compare different hybrids to each other. To the extent that standardized measures and methodologies for data collection are lacking, it may be very difficult to provide comparable information of this kind.

Accuracy and Credibility

Another problem to anticipate is that of guaranteeing the accuracy and credibility of information. Assuming that new sources become available (with no direct link to the consumer, like an employer would have) and that their information is not always consistent, how will people know who to believe? How will they know whether the differences in what they see really matter? How will they know which information is patently bad? How will they find the information that is good?

This is especially a concern with information disseminated through the Internet, which is based on the premise of open access. The challenge is to reconcile that culture with the need to impose some controls on the information that consumers see. Many organizations have been looking into the notion of accrediting information on the Internet, and some (such as URAC) have already taken steps in this direction. The idea is that sponsors of Web-based health care information would go through an accreditation process in which someone would assess things like the source of the data, its timeliness, and its accuracy. Similarly, government, employers, or private organizations could confer a seal of approval on sites that meet certain standards. There are also companies that rate Web sites, and health portals on the Web that impose journalistic standards on electronic information. Another option is to rely on a code of ethics. The intent of all of these strategies would be to help consumers find useful information and have some confidence in the information they see.

The Financing of Information Initiatives

Who will pay for the collection, production, and dissemination of comparative information to consumers? And how much is this information really worth? Consumers currently pay for some comparative information (for example, by buying *Consumer Reports* or other media comparing products and services), but they are also accustomed to getting a great deal of comparative information for free from Internet-based companies and from their employers. If consumers will not foot the bill explicitly in the private market, will they pay for it implicitly through higher premiums or taxes? And if consumers do not value the information enough to pay

for it, does that mean that it is a public good—and thus an appropriate job for the government—or that the information should not be produced?

Concerns about Equity

Researchers in the field of consumer information generally believe that it may take several years for health care consumers to become aware of the data, let alone use it, but that eventually most people will become interested. However, there will always be segments of the population that will never use comparative information or any form of decision support. Some people may simply prefer to be told what to do. For others, the more likely problem is that the materials and support being offered do not speak to their concerns, lifestyles, and values. Finally, there is a substantial segment that lacks the education and language, literacy, and other skills needed to access, understand, and use printed and electronic information. This can be a serious problem for immigrant populations and others for whom English is not a primary language.⁴¹

Assuming that the use of consumer information succeeds in helping people make better decisions, what steps can be taken to make sure that the pertinence and usefulness of information is not limited to consumers with certain characteristics? And what alternatives can be offered to those who cannot (or will not) use the data? Through research sponsored by the Agency for Healthcare Research and Quality and the Centers for Medicare and Medicaid Services, the federal government is already involved in efforts to better understand the current disparities in health care quality across racial and ethnic groups. As people start to use consumer information, the government may have a role to play in ensuring that the data do not result in an even greater gap.

Assessing Risk

Experts on issues related to consumers' health care choices are concerned that people will need to know more than basic information about costs and quality to choose among different coverage options. To figure out what kind of benefit package they need and weigh the financial consequences of their decisions, consumers will have to have some way of understanding their risk exposure. How likely are they to experience certain health events, such as the need for hospital services? What level of costs are they likely to incur under different scenarios? What trade-offs are they making if they choose the option that offers all the coverage they think they want versus the option that only offers what they are likely to need? This kind of sophisticated and

personalized decision support will take many years to develop, although some basic guidance could likely be provided in the short term through actuarial tools that calculate risk for a given age and gender.⁴²

CONCLUSION

The comparative information discussed in this paper is but one element of the broad infrastructure that will have to be developed if individual health care consumers are to be expected to find their way through a health care environment that lacks the constraints imposed by today's employers. New regulations, for example, may be needed to ensure that individuals do not find themselves priced out of the market. Brokers may have to offer a more expansive line of products as well as services that would complement and possibly substitute for the support now offered by many employers.

Moreover, the ability to produce and disseminate comparative information for consumers will depend on the health care industry's ability to develop its infrastructure of information systems in a way that promotes the collection of useful data. While current efforts to standardize data elements and transmission protocols (as required by the Health Insurance Portability and Accountability Act of 1996) are certainly a step in the right direction, it will likely be several years before all providers, health plans, and hybrid organizations can reliably generate the kinds of data needed for performance and other measures. On the other hand, it may also take that long to resolve questions related to what information consumers will really need and use as the health care environment becomes even more complex than it is today.

ENDNOTES

1. Kaiser Family Foundation/Health Research and Education Trust (KFF/HRET), *Employer Health Benefits: 2001 Annual Survey*, Kaiser Family Foundation/Health Research and Education Trust, 17; accessed November 8, 2001, at <http://www.kff.org>.
2. Julie Appleby, "Health Insurance Prices to Soar: Premiums Expected to Increase 13% or More Next Year," *USA Today*, August 27, 2001, A1; accessed November 6, 2001, at <http://www.usatoday.com/usatoday/20010827/3578249s.htm>.
3. "Many Employers Get No Quality Data on Their Health Plans," *Reuters Health*, March 8, 2001; accessed May 9, 2001, at <http://www.medscape.com/reuters/prof/2001/03/03.09/20010308econ001.html>.

4. "Employers Would Consider Pulling Health Benefits If Costs Keep Rising, Survey Says," *Reuters Health*, May 1, 2001; accessed May 4, 2001, at <http://managedcare.medscape.com/reuters/prof/2001/05/05.02/20010501prof001.html>.
5. Eighty-two percent of uninsured people reside in households with at least one worker (either part-time or full-time). See Catherine Hoffman and Mary Pohl, "Health Insurance Coverage in America, 1999 Data Update," Kaiser Commission on Medicaid and the Uninsured, Menlo Park, California, December 2000, 5; accessed November 20, 2001, at <http://www.kff.org/content/2001/2222/2222.pdf>.
6. Kaiser Family Foundation/Agency for Healthcare Research and Quality (KFF/AHRQ), *National Survey on Americans as Health Care Consumers: An Update on the Role of Quality Information*, conducted July 31–October 13, 2000, Kaiser Family Foundation/Agency for Healthcare Research and Quality, December 2000, Chart 9; accessed November 20, 2001, at <http://www.kff.org/content/2000/3093/AHRQToplines.pdf>.
7. KFF/HRET, *Employer Health Benefits*, 56.
8. KFF/AHRQ, *National Survey*.
9. According to a recent survey, 84 percent of insured Californians say they can change doctors. See Sandra H. Berry, Julie A. Brown, Mark D. Spranca, Ann F. Monroe, and Lisa Payne Simon, *Taking the Pulse of Californians: A Survey of Consumer Attitudes on Health Care Quality*, vol. 1 (preliminary version), California HealthCare Foundation, Oakland, California, November 27, 2000.
10. KFF/AHRQ, *National Survey*, Chart 18.
11. KFF/AHRQ, *National Survey*, Charts 1, 17, 20, 21.
12. KFF/AHRQ, *National Survey*, Chart 20.
13. KFF/AHRQ, *National Survey*, Chart 18.
14. David Aquilina, "Will Consumer-Driven E-Health Plans Reward Physicians for Quality?" *QIPhysician.com*, Premier Healthcare Resource, Inc., December 2000; accessed November 7, 2001, at http://www.qiphysician.com/cgi-local/display_article.cgi?864.
15. KFF/AHRQ, *National Survey*, Charts 4, 5.
16. Berry et al., *Taking the Pulse*. See also Stephen Robitaille, "The Tug-of-War over Physician Performance Data," *California Healthline*, California HealthCare Foundation, August 7, 2000; accessed November 8, 2001, at <http://www.chcf.org/features/index.cfm?itemID=1651>.
17. Research studies by Judy Hibbard and colleagues explore the idea that consumers may respond better to a negative message about health care quality than a positive one. See Judith H. Hibbard, Lauren Harris-Kojetin, Paul Mullin, James Lubalin, Steve Garfinkel, "Increasing the Impact of Health Plan Report Cards by Addressing Consumers' Concerns," *Health Affairs*, 19, no.5: 138-143.
18. The provider-level CAHPS (Consumer Assessment of Health Plans Study) survey, which is currently in development, will facilitate the reporting of standardized measures of patients' experiences with physician care.
19. Vivius is a Minneapolis-based startup that eliminates the "middle-man" by enabling employees to handpick their own individual network of providers. For more information, see <http://www.vivius.com>.
20. "Out of the Frying Pan onto the Cutting Edge: A Conversation with Lee N. Newcomer, M.D.," *Managed Care*, 9, no. 7 (July 2000); accessed November 7, 2001, at http://www.managedcaremag.com/archives/0007/0007.qna_newcomer.html.
21. Aquilina, *Consumer-Driven E-Health Plans*.
22. Christopher J. Gearon, "Consumer Access to the National Practitioner Data Bank: The Wave of the Future," *Healthplan*, 41, no. 6 (November/December, 2000): 14-17; accessed November 7, 2001, at <http://www.medscape.com/AAHP/healthplan/2000/v41.n06/hp4106.02.gear/hp4106.02.gear.html>.
23. Robitaille, *Tug-of-War*.
24. Gearon, "Consumer Access." See also William H. Maruca, "M.D. Online Ratings Raise Concerns," *Physician's News Digest*, September 2000; accessed November 7, 2001, at <http://www.medscape.com/PNDI/PND/2000/09.00/pnd0900.02.maru.html>.
25. The 106th Congress did not hold hearings on the bill.
26. KFF/AHRQ, *National Survey*, Charts 10-12.
27. Berry et al., *Taking the Pulse*, 23.
28. KFF/AHRQ, *National Survey*, Charts 22 and 23.
29. Carol Cronin, conversation with author, May 9, 2001.
30. KFF/AHRQ, *National Survey*, Charts 10-12, 16.
31. Shoshanna Sofaer, conversation with author, May 16, 2001.
32. Berry et al., *Taking the Pulse*, 23-24.
33. The 1992 National Adult Literacy Survey (NALS) found that "21 to 23 percent—or some 40 to 44 million of the 191 million adults in this country—demonstrated skills in the lowest level of prose, document, and quantitative proficiencies (Level 1)." See Irwin S. Kirsch, Ann Jungeblut, Lynn Jenkins, and Andrew Kolstad, *Adult Literacy in America: A First Look at the Findings of the National Adult Literacy Survey*, National Center for Education Statistics, August 1993; accessed November 7, 2001, at <http://nces.ed.gov/naal/resources/resources.asp>.
34. Seven percent said this type of information would have "a lot" of influence on their choice of a new doctors, 12 percent said this for hospitals, and 8 percent for health plans. KFF/AHRQ, *National Survey*, Charts 10-12.
35. Berry et al., *Taking the Pulse*, 34.

36. Judith H. Hibbard, Paul Slovic, and Jacquelyn J. Jewett, "Informing Consumer Decisions in Health Care: Implications from Decision Making Research." *Milbank Quarterly*, 75, no. 3 (September 1997): 395-414. For more on the current state of decision support, see Veronica Goff, "Consumer Health Care Decision Support: State of the Art," *Executive Brief*, National Health Care Purchasing Institute, Washington, D.C., July 2001.
37. KFF/AHRQ, *National Survey*, Chart 24. The 50 percent response is consistent with responses to a similar question in the RAND/CHCF survey (Berry et al., *Taking the Pulse*, 34).
38. Berry et al., *Taking the Pulse*, 32.
39. Christine Molnar, Reporting Health Care Quality to Minority Populations: Issues and Challenges, unpublished, prepared for the National Quality Forum, June 2001.
40. In recognition of this problem, the foundation of the American Board of Internal Medicine has initiated a ten-year program to work on issues related to physician quality, including the development of public measures. See "Project Physician Quality," ABIM Foundation; accessed November 7, 2001, at <http://www.projectphysicianquality.org>.
41. Molnar, Reporting.
42. Shoshanna Sofaer, conversation with author, May 16, 2001; Judith Hibbard, conversation with author, May 14, 2001.