Bottom Line: Can Consumers Survive Value-Based Health Care?

written by Theresa Hush | December 19, 2019

As 2019 nears its close, health care has reached a crossroads. Value-Based Health Care was intended to clarify consumer choices and motivate providers to offer high value services that improved outcomes, as well as to improve patient access to those services. But has that goal been realized? Has anything really changed? Or are health care consumers even worse off than before?

Since September, we've been evaluating the consumer perspective of Value-Based Health Care, examining whether the movement is helping consumers achieve affordability, better choices, and good quality. We've focused on two central questions: Is Value on the right track? Has it delivered on its promises?

To answer those questions, we've examined five key criteria:

> Can consumers identify and access high-value health care services?
> Do quality, cost, and patient experience reflect the current criteria for Value?

Are measures adequate to reflect the criteria, and to see performance?
What should ACOs and providers do to meet consumer needs for Value?
What are the critical tools providers need to enhance Value?

Consumers Are Trapped by High Costs with Unknown Value to Guide Choices

These criteria presume that consumers have the agency and resources to make informed medical choices. We've held that presumption up to the light, assessing whether consumers actually have the tools to compare quality of providers—and if not yet, whether quality measurement is moving in a direction that will help consumers. We've suggested how consumers can improve their skills in health care cost management and medical decision-making to avoid unnecessary costs.

Likewise, whether consumers have the tools to evaluate costs is a major issue. We've explained the tragic consequences for consumers who still lack transparent cost information from providers while simultaneously bearing a larger share of expenses and facing more restricted benefits. On the provider side, we've examined both the financial and ethical imperatives for providers to reorient themselves to help consumers engage in their health care with better knowledge and tools.

This is the bottom line of our analysis: Value-Based Health Care is still not a reality for consumers. While insurance benefits and employer benefit plans have shifted a much higher proportion of costs onto consumers, those consumers lack the essential tools to compare costs and quality and to manage their care. And even if they had those tools, financial incentives within health care organizations to achieve high patient volume discourage clinicians from providing the quality information or adequate time for consumers to make fully informed medical decisions. All too often, the resultant Hobson's Choice for too many consumers is one of forgoing essential health care services or facing financial disaster.

Reimbursement Incentives for Providers Still Favor Volume over Value

While hospitals and physicians are beginning to engage in financial risk payment models, these plans are still in the minority. Only about a third of total payments to providers are associated with accountability for Value, and a fraction of those reflect serious fixed cost pricing like capitated or bundled payments.

Why is financial risk important? Because it has the potential, in theory, to align providers and

patients toward the same goals of improved outcomes and lower cost. The historical Fee-for-Service reimbursement method, instead, rewards for higher volume of more costly services. However, no one can believably demonstrate how much costs can be reduced through financial risk. Value-Based Health Care is an unproven effort, even if there are components intended to improve the health care system.

As a result of slow movement toward financial risk, physicians are still being compensated according to the number of patients seen and services provided, and their employers—often hospitals—are tying compensation plans to downstream services as well as their service-based revenues. That translates into disincentives for spending more time engaging in patient decision-making, and little support for the extra effort required at educating consumers and patients. Additionally, hospitals and physicians continue to resist the cost transparency that consumers need.

Despite these payment models, however, some providers recognize the possibilities of working with consumers and are becoming more responsive. The more competitive environment between consolidated health systems has led to competition for patients. Telemedicine appointments and specialty care bundled payments with transparent pricing are tools that benefit consumers. There is a noticeable upswing in consumer-directed messaging and outreach.

How Can Consumers and Business Leverage Change in Health Care?

Although consumers collectively have not challenged health care costs and coverage, that began to change under the threat of repealing the Affordable Care Act in 2017. Facilitated by the expansion of high deductible health plans and higher costs in general, a health care consumerism movement has been slowly emerging. There are now multiple consumer groups actively engaged in challenging many aspects of health care.

In addition, business has recognized opportunities to help consumers become more actively engaged in their health care and its costs. From design products to self-managed health care, from not-for-profit websites that collect and compare cost of services by region to consumer-directed groups that aggregate member data for medical research, there is a wealth of non-provider activity directed at increasing consumer leverage.

Whether these efforts create enough momentum to achieve consumer goals under Value-Based Health Care, however, is still uncertain. At present, collective action has not yet reached a level to propel systemic change, and issues remain mired in political debate.

Consumer health care costs are exacerbated by the changing scope of coverage and high-deductible health plans. We must ask how Value-Based Health Care solutions to improve consumer choices, even if they could be achieved, can resolve the basic problem of an unaffordable cost burden. Even a good system of transparency cannot fix the reality of high health care costs that unevenly hit consumers, regardless of ability to pay.

It's not a stretch to imagine that the cost burden already in place for consumers will become a financial crisis first for consumers and then providers, if we don't move faster to change the economics of health care.

More effort by all stakeholders to foster higher medical literacy and a better understanding of coverage, consumer tools for questioning and deciding about services, and access to valid data for comparison shopping are the basics for surviving Value-Based Health Care. But consumers should also not bear the cost of an inefficient system. Government, providers, employers and health plans have the singular ability to create a system that is prepared for consumer responsibility and to preserve our most precious resources—people.

Founded as ICLOPS in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.

Image: Annelie Turner