SMASHING INTO WINDOWS: The Limits of Consumer Sovereignty in Health Care

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FONDATION BROCHER

CHOICE I:

Shopping for Treatments

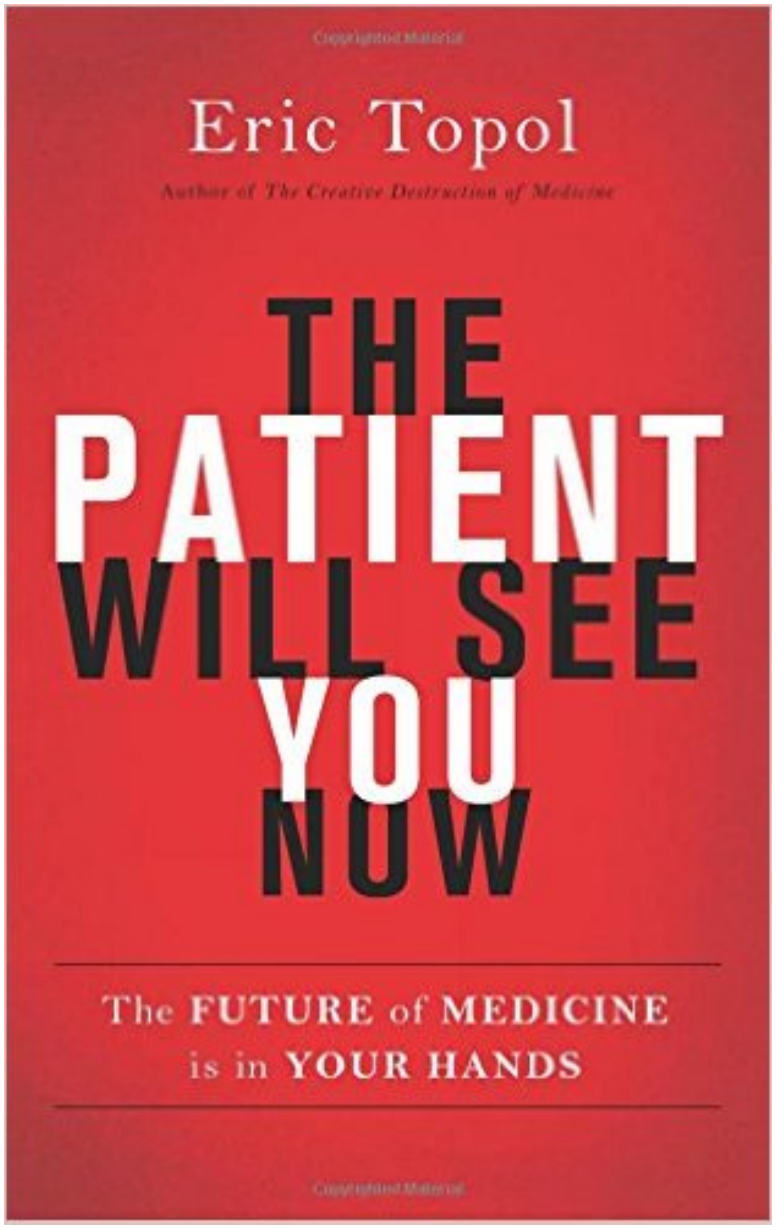
THE FLOWERING OF CONSUMERISM

It is an economic idea at its core: as consumers we can engage in rational decision making and wisely choose among services and products. How? By shopping for services and products that give good value (low risk, high quality and low price).

This flowering of consumerism has spread to medicine. We imagine ourselves as model patients – skeptical, aggressive, and self-reliant.

We will be the "new sick" managing our own illnesses, processing risk and cost information, and partnering with our doctors.


"A book no household should be without."
—SANJAY GUPTA, MD
THE
EMPOWERED
PATIENT
HOW TO
Get the Right
Diagnosis
Buy the
Cheapest
Drugs
Beat Your
Insurance
Company
AND
Get the Best
Medical Care
Every Time
ELIZABETH COHEN
CNN SENIOR MEDICAL CORRESPONDENT


Eric Topol
Author of The Creative Destruction of Medicine
THE
PATIENT
WILL SEE
YOU
NOW
The FUTURE of MEDICINE
is in YOUR HANDS

THE PATIENT IS IN CHARGE

Eric Topol, *The Patient Will See You Know: The Future of Medicine Is In Your Hands.*

"Patients will be increasingly in charge through iPhone and laptop apps, armed with evidence based information about health problems……Information and expertise will be readily available to all, without having to go to the doctor's office, and new technologies will make it possible to "predict and preempt" many major ills — all of which ultimately will contribute to the "emancipation" of consumers."

I. GOALS OF MEDICAL TRANSPARENCY

A. PROMOTING PATIENT AUTONOMY THROUGH CHOICE

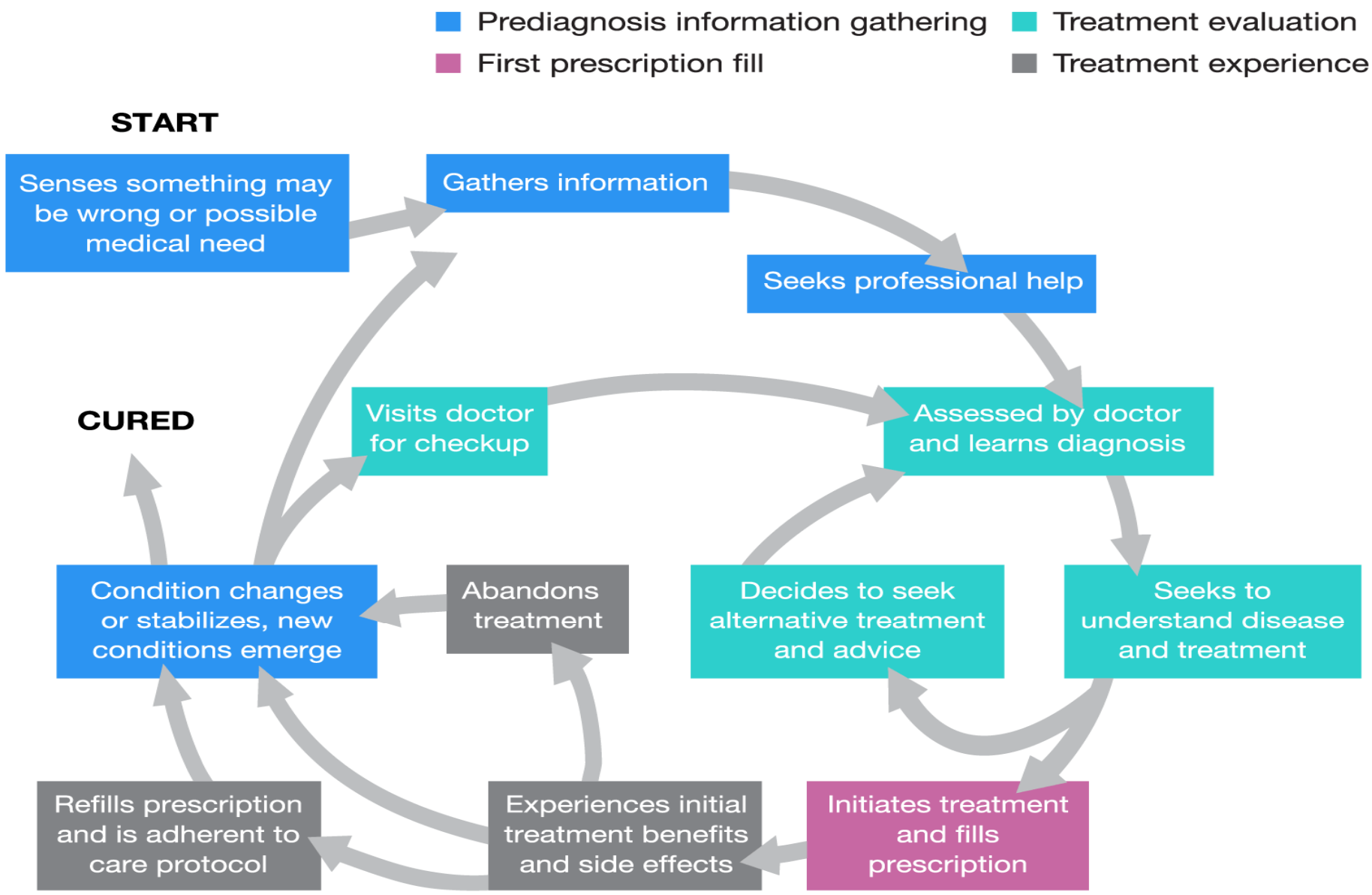
Bioethics begins with patient rights and strong versions of autonomy.

***Autonomy* is "… the ground of the dignity of human nature and of every rational nature." Immanuel Kant. Autonomy is grounded in the right and ability to make choices. Surely then the language of consumer sovereignty in health care makes sense—if we allow individuals more and more spheres of decisionmaking, from treatment elections to insurance selections, then we maximize their autonomy in the health care setting at least.**

B. IMPROVING MEDICAL DECISIONMAKING

- **Monitor errors and mismanagement, inattention, staff foul-ups**
- **Control costs by detecting wasteful ideas, profitable only to the hospital**
- **Detect gaming and medical actions based on external financial reasons.**

CareFlow maps how people make healthcare decisions.



McKinsey&Company | Source: Pharma3D.com; McKinsey analysis

II. LIMITS ON PATIENT HEALTH CARE CHOICES

A. PROVIDER LIMITS: TREATMENT RISKS

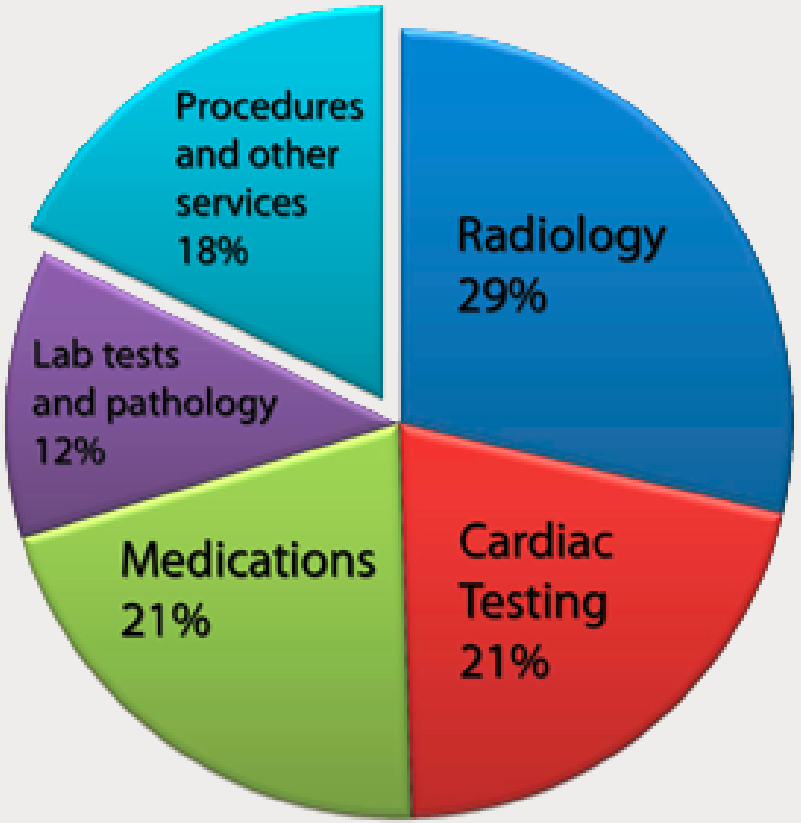
1. Unnecessary Treatments. Medical practice variation and medical uncertainty create barriers to accurate communication of treatment necessity and risk assessment. Providers too often offer care that is not "trustworthy", i.e., it is of uncertain and therefore questionable value. Many drug therapies and most dietary supplements are wasteful of resources and without proven benefit. Off-label prescribing is often the triumph of hope over evidence.

2. Low Quality Treatments. Americans receive appropriate, evidence-based care when they need it around half the time. All Americans are at risk of receiving poor care— regardless of where they live, how much money they have, or their race, education or health insurance. Tens of thousands of Americans die each year as a result of preventable hospital errors. Legally driven conversations between doctor and patient hardly begin to address the preexisting problems of unnecessary and poor quality treatments offered by providers.

3. Unaffordable Treatments. Patient care is often denied because of high cost. Even beneficial treatments may be too costly for either patient or insurer to pay for.

'Medical Excess'

Here's a breakdown of what services 26 specialty societies, that participated in the Choosing Wisely campaign, say are overused.



Source: Dartmouth Institute for Health Policy & Clinical Practice and The New England Journal of Medicine

B. PROVIDER POWER: THWARTING PATIENT DECISIONS

1. Doctors Direct Patient Decisions. They may overstate the benefits, overstate their experience with a procedure, or intimidate patients through a range of psychological devices. Hoffman and Del Mar write:

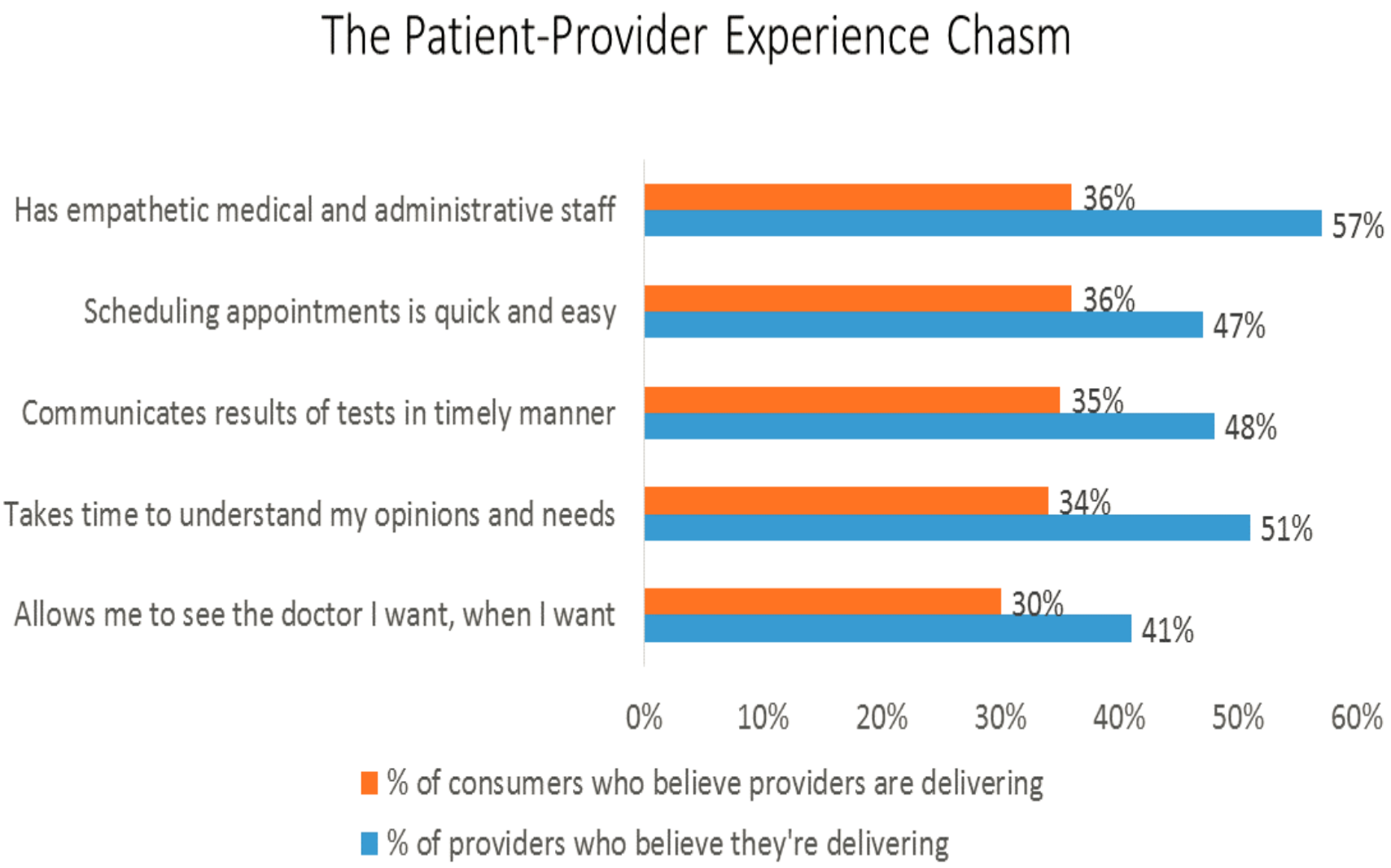
> ***"Clinicians rarely had accurate expectations of benefits or harms, with inaccuracies in both directions. However, clinicians more often underestimated rather than overestimated harms and overestimated rather than underestimated benefits. Inaccurate perceptions about the benefits and harms of interventions are likely to result in suboptimal clinical management choices."*** **Tammy C. Hoffman and Chris Del Mar, Clinicians' Expectations of the Benefits and Harms of Treatments, Screening, and Tests: A Systematic Review, 177 JAMA Intern.Med 407 (March 2017)**

2. Doctors Misuse Consent Forms. The formality of legal compliance protects providers while obfuscating risks and alternatives, a ritual without teeth.

3. Doctors Don't Communicate Well. Doctors often lack empathy, are poor listeners, are rushed in their clinical encounters, or have distaste for or have unconscious biases against certain classes of patients. And at the same time they believe they are doing well.

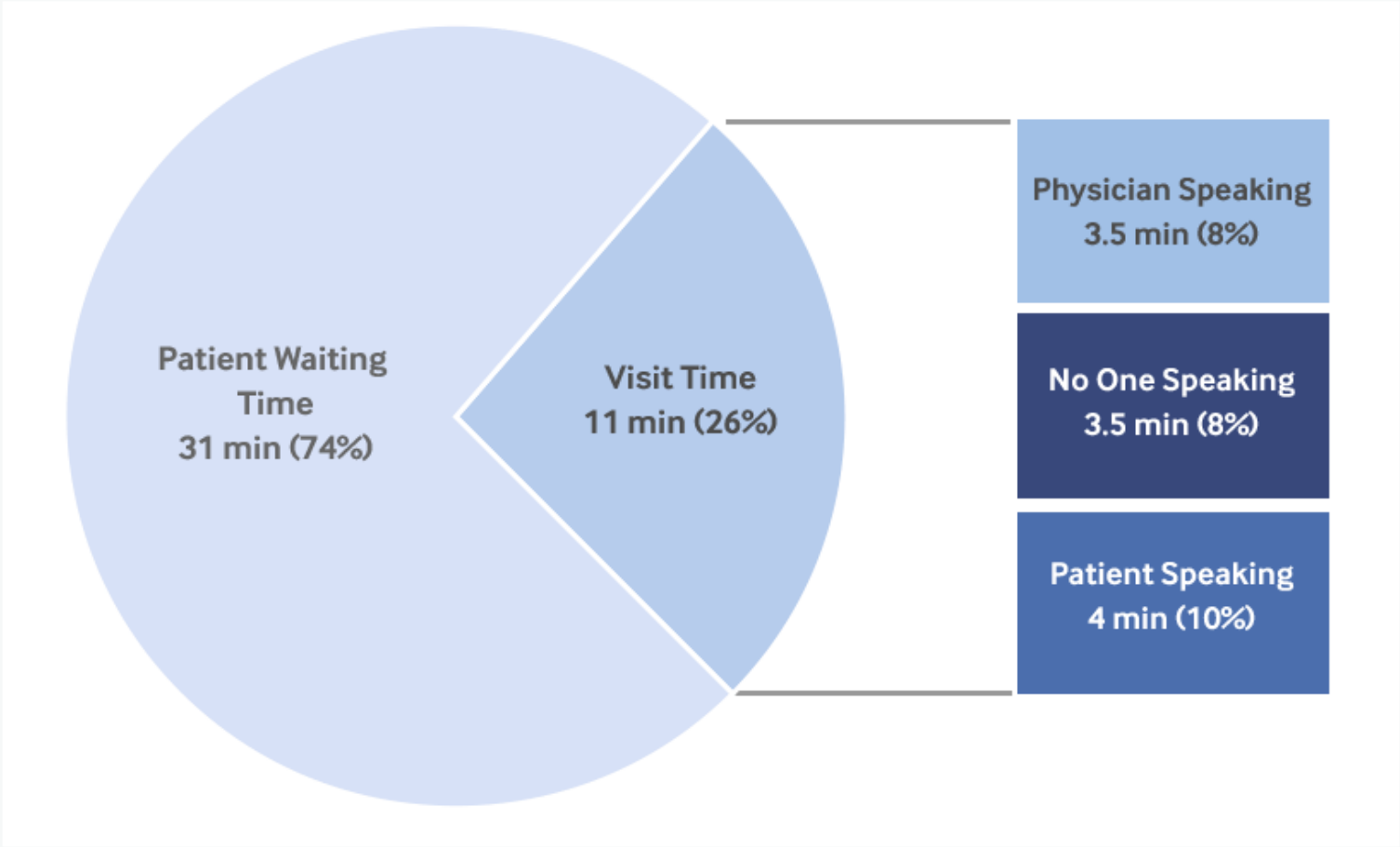
4. Doctors Can Be Bribed to Prescribe Brand Name Drugs and Devices. A $15 sandwich given by a drug or device manufacturer to a doctor changes prescribing patterns, and the more costly the sandwich, the bigger the change.

5. Doctors Resist Disclosure of Error Rates and Personal Performance Data. Disclosure to a patient of a medical error that has resulted in serious harm is considered a bioethical imperative that informs patients about the particular risks that a doctor may pose. Yet full error disclosures are rare.



Source: Patient Experience: It's Time to Rethink the Consumer Healthcare Journey, GE Healthcare Camden Group and Prophet, March 2016

Breakdown of Visit Time



Source: Rhoades DR, McFarland KF, Finch WH, Johnson AO. Speaking and interruptions during primary care office visits. Family Medicine. 2001 July - August; 33(7):528-32.

50% OF PATIENTS
walk out of the physician's office
NOT KNOWING
what they were told or are supposed to do.


THE TIMES-PICAYUNE
©2007
NOW...THIS MEDICATION CAN CAUSE WEIGHT GAIN.
HOW SO?
THE DRUG COMPANY WINES AND DINES ME FOR PRESCRIBING IT.
℞

A $15 hoagie provided by a pharm rep to a primary care doctor changes her prescribing patterns.

Physician Payment Sunshine Act: makes pharma gifts to doctors transparent on a website.

=

C. HOSPITAL AVOIDANCE OF CONSENT OBLIGATIONS

Hospitals have no legal duty to obtain a patient's consent to surgery, nor to conduct any kind of inquiry into the quality of the plaintiff's consent.

Hospital are supposed to help their independent medical staffs use consent forms, but typically such forms are little more than a ritual, without no real conversation about risks.

These hospital consent forms are treated in many states as presumptively valid consent to the treatment at issue, with the burden on the patient to rebut the presumption.

D. PATIENT LIMITS: BOUNDED RATIONALITY

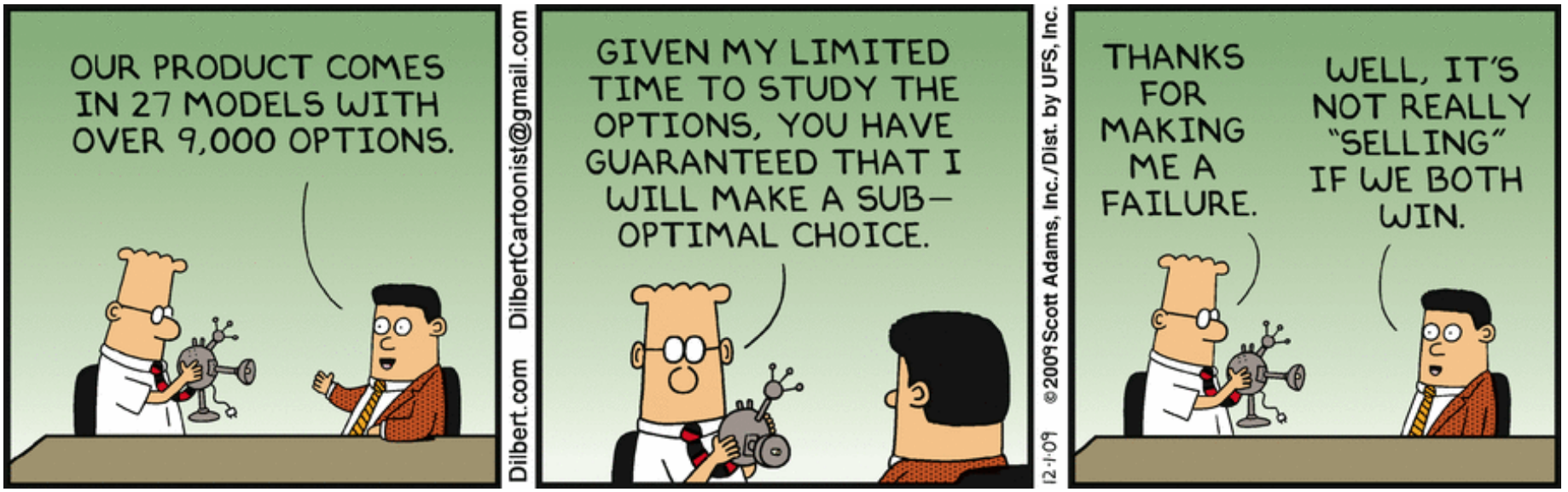
1. Patients Struggle to Process Medical Information. Average functional health literacy and numeracy in the United States are extremely low. Social class and income level matters in terms of rational decisionmaking. Health information is hard to process even when providers make serious attempts to communicate. Most patients neither understand nor remember information even when well communicated to them.

2. Patients Refuse Treatments Because of Belief Structures. Patients may be anxious about effective treatments for irrational reasons such as fears of the knife or phobic feelings about diseases such as cancer.

3. Disclosure May Not Matter to Patients. Studies suggest that risk information will go unused in any event, since patients rarely change their minds. Patients also tend to make one-reason decisions when considering treatment options for serious ailments, where multiple factors should be considered.

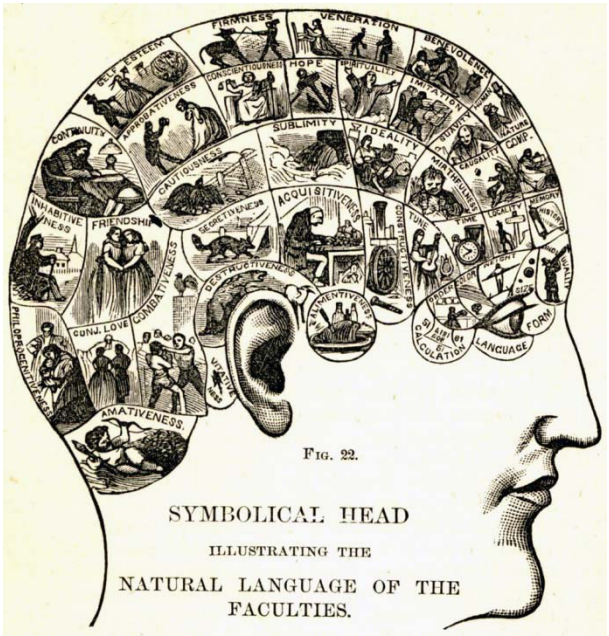
4. Patients as Consumers Can Be Seduced by Powerful Marketing. Vendors of drugs, supplements and medical devices market to circumvent patient rationality. Vendors market to doctors as agents of patients, and sometimes they sell doctors a bill of goods. And direct-to-consumer advertising of drugs can, like sugar, be addictive and dangerous as patients push doctors to prescribe unnecessarily.

People's tastes can also create excess demand for health care, and Americans have a strong appetite. Cultural norms can encourage a desire for health care. One poll found that 34% of Americans thought that modern medicine could cure almost any illness, compared to only 27% of Canadians and 11% of Germans. These American attitudes are likely to lead to greater trust in and reliance on advanced medical procedures.


OUR PRODUCT COMES IN 27 MODELS WITH OVER 9,000 OPTIONS.
Dilbert.com DilbertCartoonist@gmail.com
GIVEN MY LIMITED TIME TO STUDY THE OPTIONS, YOU HAVE GUARANTEED THAT I WILL MAKE A SUB-OPTIMAL CHOICE.
12-1-09 ©2009 Scott Adams, Inc./Dist. by UFS, Inc.
THANKS FOR MAKING ME A FAILURE.
WELL, IT'S NOT REALLY "SELLING" IF WE BOTH WIN.

Patients face the problem of bounded rationality. "Health care decisions are, by their nature, choices in which the stakes are high, the potential for regret substantial, and the emotional overlays pervasive…. "Bounded Rationality and the Conceptual Underpinnings of Health Policy: A Rationale and Roadmap for Addressing the Challenges of Choice in Medical Settings" Mark Schlesinger and Brian Elbel (2006)

Information Selection	Information Processing	Decision	Evaluation of the Decision
Availability Bias	Representativeness Bias	Mental Accounting Bias	Hindsight Bias
Selective Perception Bias	Conservatism Bias and Herding Bias	Endowment Bias and Sunk Costs Bias	Prospect Theory
	Anchoring Bias		
	Framing Bias		
	Overconfidence Bias		
	Optimism Bias		



Patients are ill, and illness makes them vulnerable:
Illness disables. Sick bodies rebel, and the ill are defeated.
Illness pains. The faltering body hurts.
Illness exhausts.
Illness erodes control.
Illness enforces dependence.
I**llness disorients. T**he sick suffer
a disturbing, exhausting strangeness
Illness baffles.
Illness terrifies.
Illness isolates. **Illness is "always a place where there's no company, where nobody can follow."**

Mark A. Hall and Carl E. Schneider, Patients as Consumers: Courts, Contracts, and the New Medical Marketplace, 106 Mich. L. Rev. (2008)

CHOICE?

III. EVOLUTION OF PATIENT DECIONMAKING: LEGAL PRESSURES

A. GENERATION 1 (*Gen1*). Informed Consent and the Doctor-Patient Relationship

The common law mandates that physicians (but not hospitals or institutions generally) obtain their patients' informed consent. Crude tools are limited by both physician and patient rationality limits.

The process has some value: the mandate for physicians to disclose and discuss material risks of a medical treatment, and alternatives to it, are perhaps the most important pieces of information for a patient to consider. **Harbeson v. Parke Davis, 746 F.2d 517 (9th Cir.1984).**

***Gen1* informed consent has clearly advanced the art of giving information to promote patient choices, but suffers from all the limits discussed previously. Informed consent doctrine has moved patients into a more important role as a reasonable patient….but consent has been poorly implemented; it is largely a desultory ritual in hospitals in particular.**

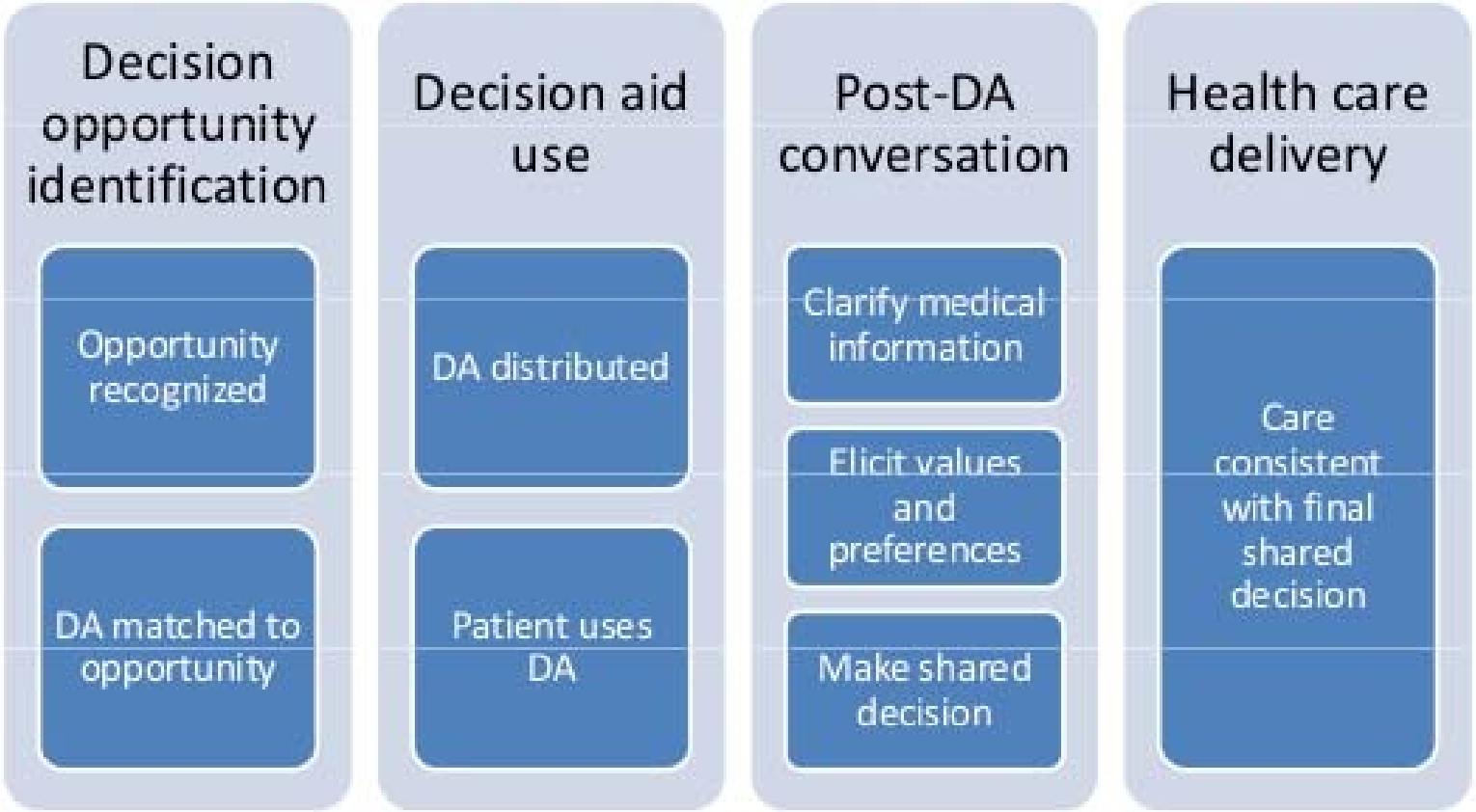

WAKE HIM UP. WE NEED INFORMED CONSENT FOR THE NEXT PART
CARTOONSTOCK .com
Search ID: shrn2774

B. GENERATION 2 (Gen2) Decision Aids and Preference Sensitive Care

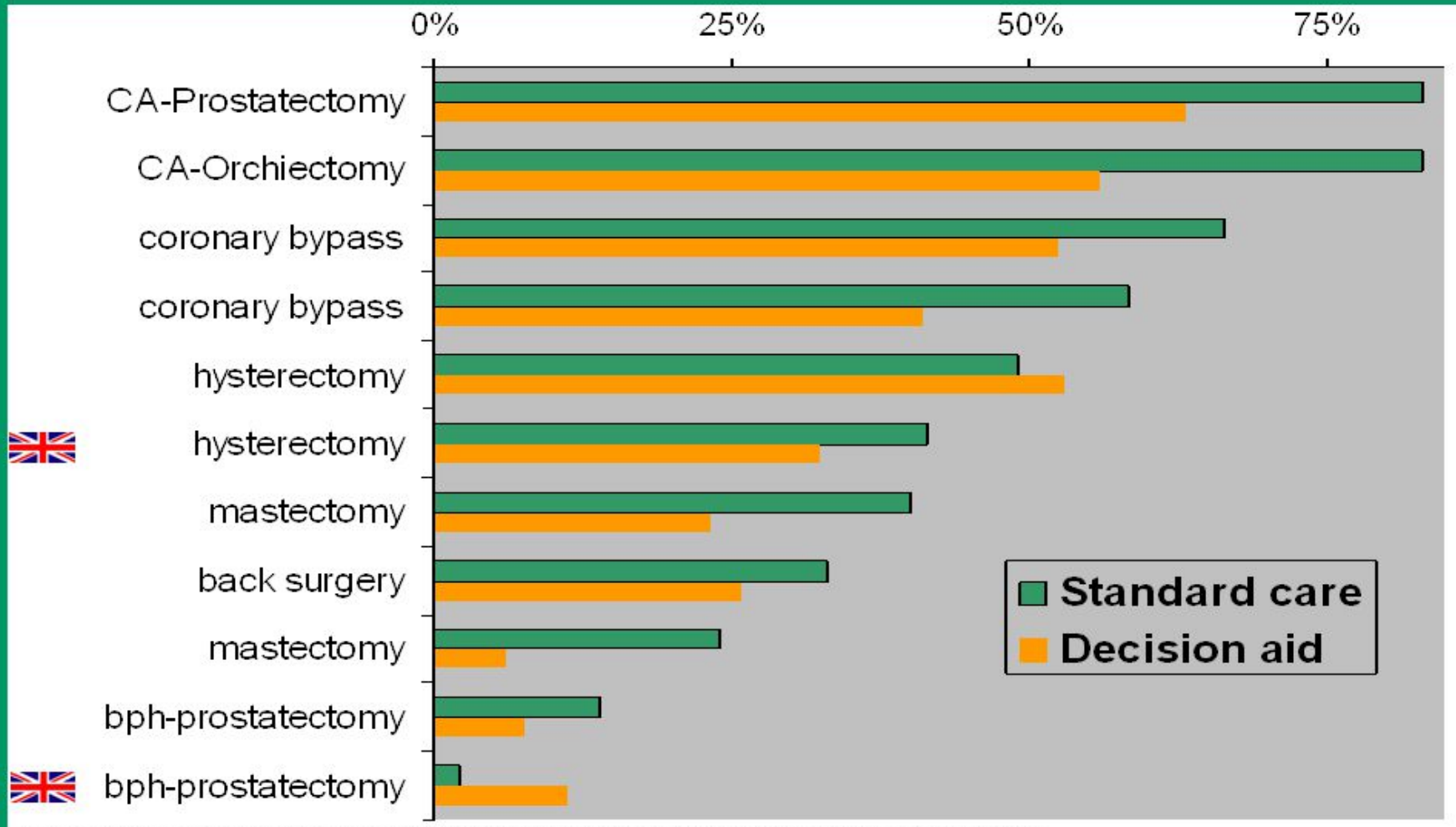
Reinforced by the ACA, this model promises improvements in patient decisional sovereignty. Decision Aids (DAs) are decision support tools that provide patients with detailed and specific information on options and outcomes, help them clarify their values, and guide them through the decision making process.

See, e.g., Elie A. Akl, et al., A Decision Aid for COPD Patients Considering Inhaled Steroid Therapy: Development and Before and After Pilot Testing, 15 BMC Med. Inform. Dec. Mak. 7 (2007).

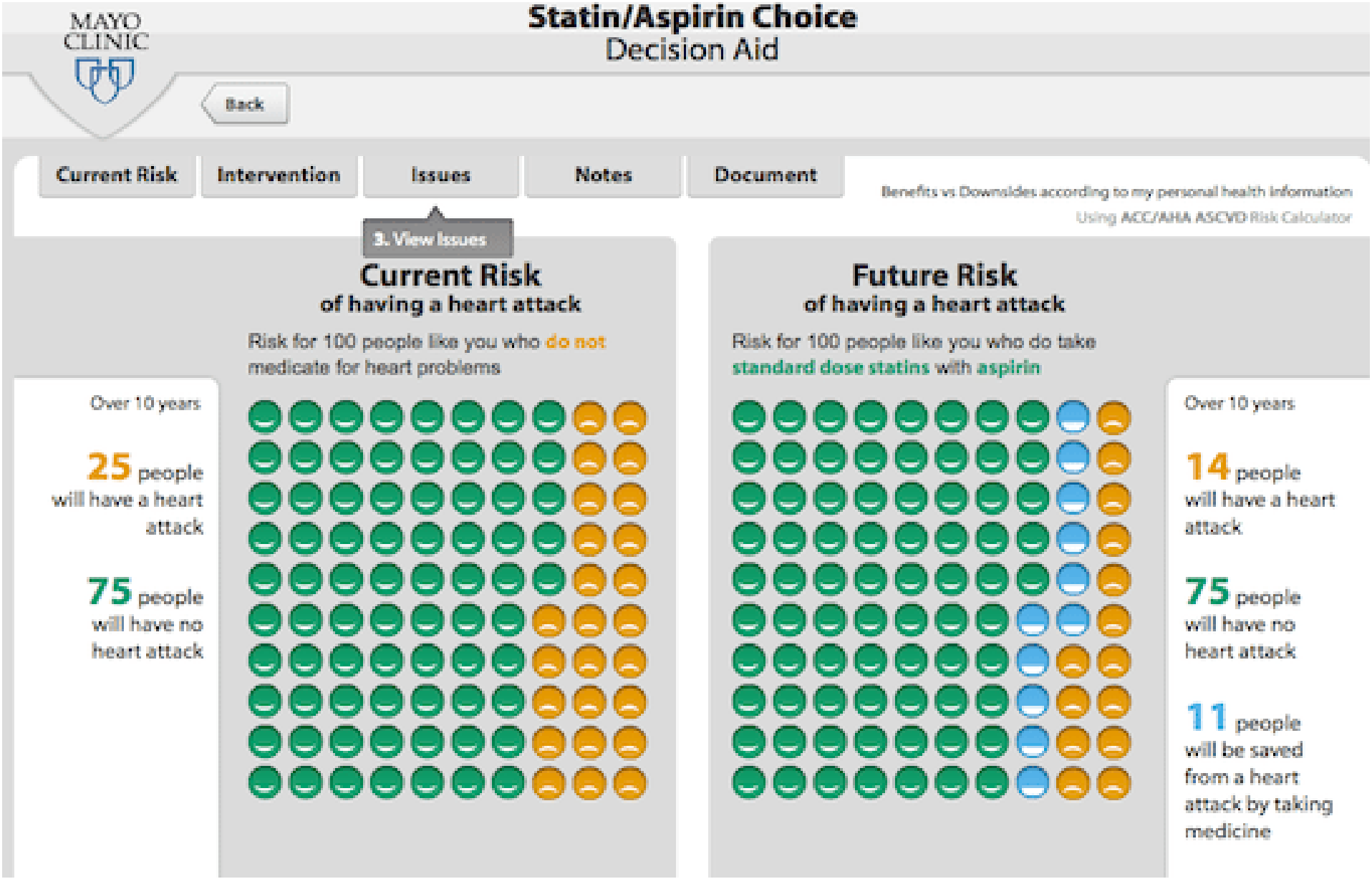
Key Steps Of Shared Decision Making Based On Decision Aids



Decision Aids tend to reduce rates of high volume discretionary surgery



Source: O'Connor et al. Decision aids for patients facing health treatment or screening decisions (review). *Cochrane Library*, 2009 volume 2.



https://statindecisionaid.mayoclinic.org/

C. GENERATION 3 (Gen3). Patient Engagement and Chronic Disease

The goal is to improve information at all levels, from patient understanding to physician access to best evidence information. Patients can benefit from live and computer-based approaches such as patient navigators, medical avatars, video games, and mobile apps. Physician ability to explain medical choices to patients can be enhanced by decision analysis tools such as microrisks. Hospitals may hire Chief Cognitive Officers.

1. Accountable Care Organizations
2. Virtual Forms of Provider-Patient Contact
3. Health Coaches
4. Social Media Platforms

1. Accountable Care Organizations

Patient engagement **is defined as a concept that combines a patient's knowledge, skills, ability and willingness to manage his own health and care with interventions designed to increase *activation* and promote *positive patient behavior*.**

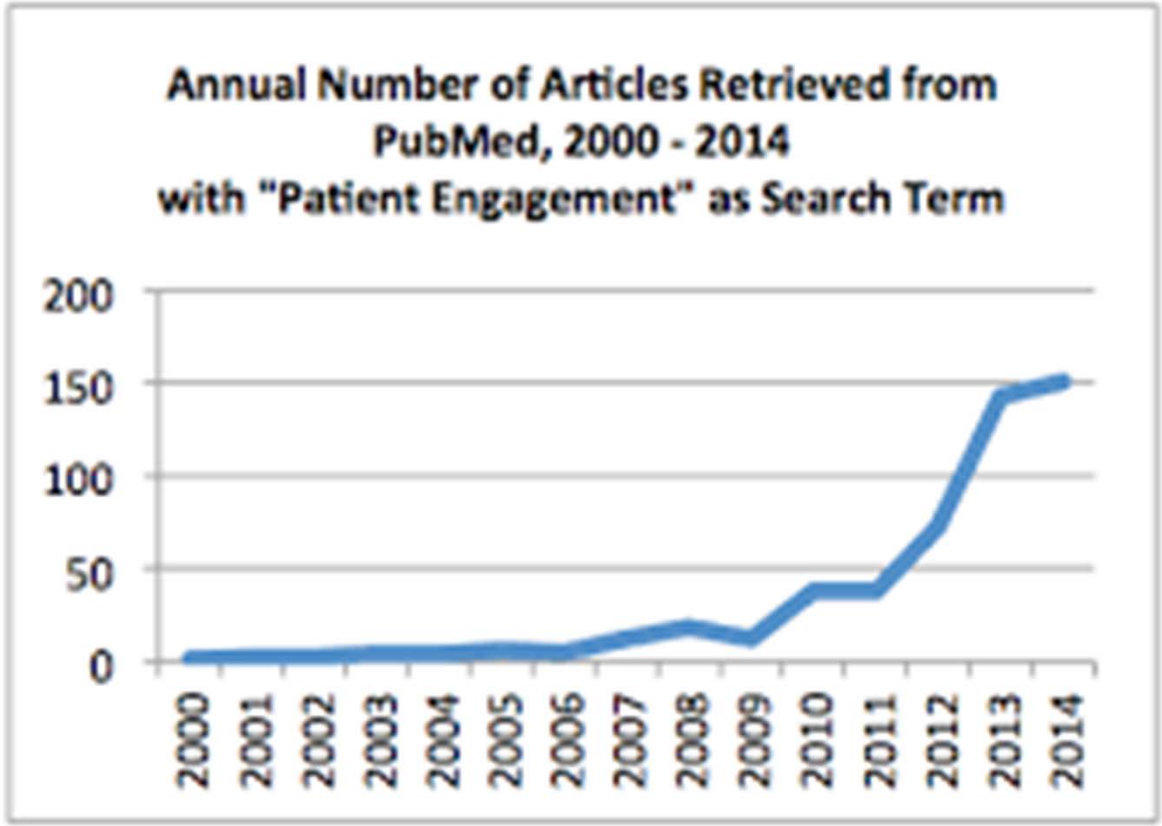
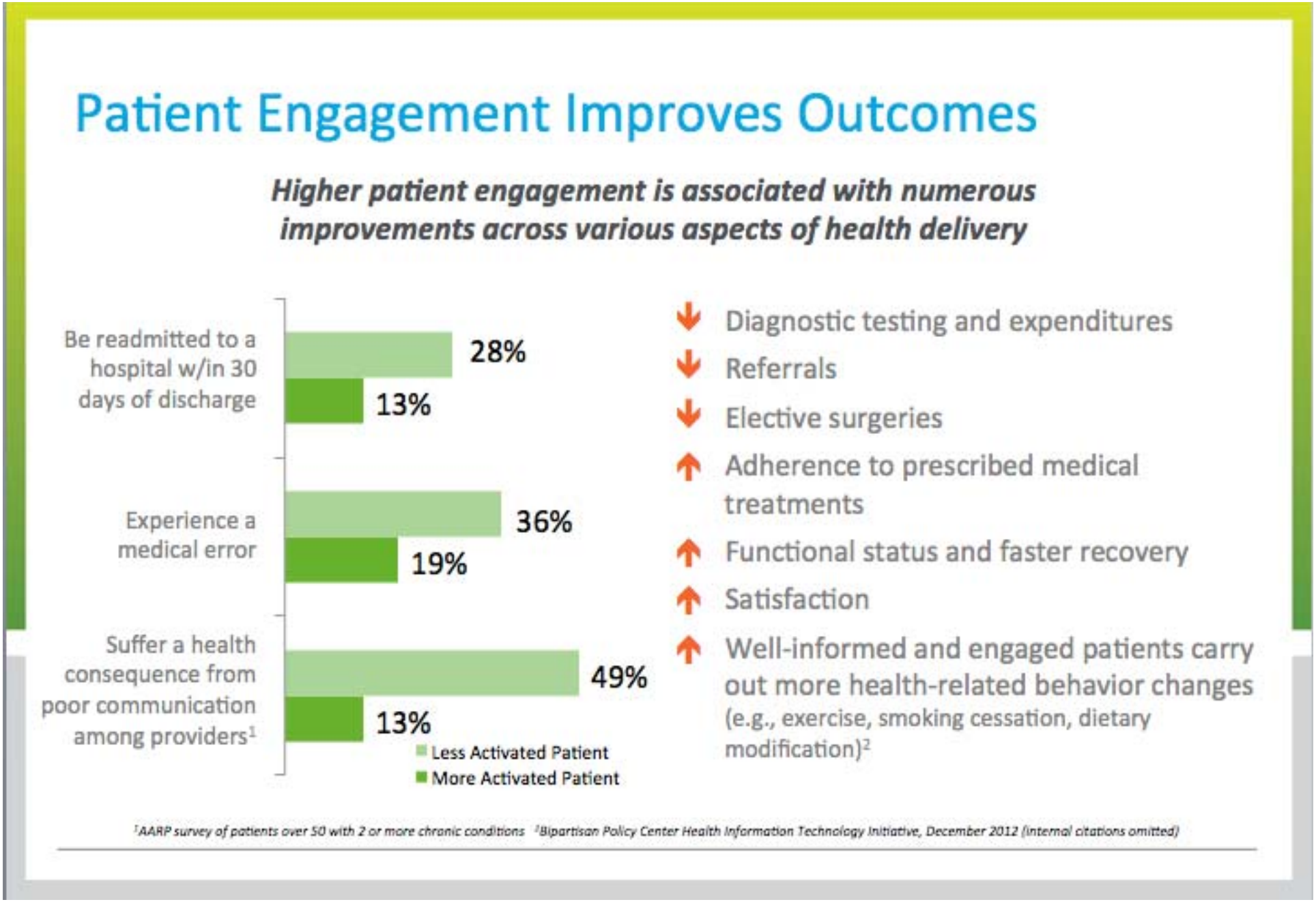


Figure 2. Annual number of articles retrieved from PubMed, 2000 – 2014, with "patient engagement" as the search term.

Surveyed ACOs' Patient Engagement Offerings

48% of surveyed ACOs cite patient engagement as most challenging activity to perform



Cortney Nicolat, Supporting ACO Success with Meaningful Patient Engagement, Becker's Hospital Review, August 1, 2013

2. Virtual Forms of Provider-Patient Contact

Virtual humans (VHs) improve clinical interviews by increasing patient willingness to disclose information. Automated VHs can help overcome a significant barrier to obtaining truthful patient information.

Gale M. Lucas et al, It's Only a Computer: Virtual Humans Increase Willingness to Disclose, 37 Computers in Human Behavior 94 (2014)

AVATARS FOR TRAINING, DIAGNOSIS AND COUNSELING

Sherry-Ann Brown, Principles for Developing Patient Avatars in Precision and Systems Medicine, 6 Frontiers in Genetics 1 (Article 365 January 2016)

https://www.youtube.com/watch?v=qL4BXXX1AX4&t=71s

WHO IS PEPPER?

Pepper is a human-shaped robot. He is **kindly, endearing and surprising**.
We have designed Pepper to be a genuine day-to-day companion, whose number one quality is his ability to perceive emotions.

Pepper is the first humanoid robot capable of recognising the principal human emotions and adapting his behaviour to the mood of his interlocutor.
To date, more than 140 SoftBank Mobile stores in Japan are using Pepper as a new way of welcoming, informing and amusing their customers. Pepper also recently became the first humanoid robot to **be adopted in Japanese homes**!

https://www.ald.softbankrobotics.com/en/cool-robots/pepper

SWEDISH CLINICS USE VIRTUAL REALITY TO REDUCE THE STING OF SHOTS

https://www.statnews.com/2016/10/27/virtual-reality-pain-app/?s_campaign=stat:rss

3. Health Coaches

4. Social Media Platforms

Social Media and Health

- More than 40% of consumers say that information found via social media **affects the way they deal with their health**

- 90% of respondents from 18 to 24 years of age said **they would trust medical information shared by others** on their social media networks (Pew Internet)

- 60% of doctors say SM improves the **quality of care** delivered to patients

Channel	Uses	Advantages	Disadvantages
Wikipedia 	Comprehensive online encyclopedia Editor-moderated content from user consensus	Trusted by patients and many physicians Comprehensive and free online information source Emphasis on self-regulation resulting in higher quality control than other social networks	Vulnerable to misinformation, though most content is to a high standard The combination of trust in Wikipedia and its vulnerability to both mistakes and author bias has caused concern within the academic and medical community[13]
Twitter 	140 character user-generated comments or 'tweets' Following other users Sharing links Commenting on personal and corporate accounts	Effective broadcasting platform, high viral possibilities Strong for news and live events such as conferences Small message size is easily digestible	Character limit makes it difficult to have any depth Hard to generate meaningful engagement Requires regular updating Very small window for meaningful engagement No central content control
Facebook 	Add friends to create a peer network A plethora of services including groups, events, games and personal messaging Sharing links	The largest social network based on numbers of monthly active users The most diverse social network Capable of detailed and engaging interactions Enhanced word-of-mouth effect from friends' activity	Regulatory adherence is more difficult and varies according to geographic region Small window for meaningful engagement Privacy concerns Very little central content control
YouTube 	Sharing video content Commenting on videos Following content creators	Favored by physicians for highly informative, detail-orientated videos Engagement correlates to emotive patient focused content Can be linked to other social networks	Videos often require a large time investment Capability to share videos within the social network is limited Filming and editing video to a suitable standard is expensive and requires specialist skills

IMS Institute for Healthcare Informatics gennaio 2014

TRUSTED VOICES ON SOCIAL MEDIA?

kimkardashian FOLLOWING

464k likes 1w

kimkardashian OMG. Have you heard about this? As you guys know my #morningsickness has been pretty bad. I tried changing things about my lifestyle, like my diet, but nothing helped, so I talked to my doctor. He prescribed me #Diclegis, I felt a lot better and most importantly, it's been studied and there was no increased risk to the baby. I'm so excited and happy with my results that I'm partnering with Duchesnay USA to raise awareness about treating morning sickness. If you have morning sickness, be safe and sure to ask your doctor about the pill with the pregnant woman on it and find out more www.diclegis.com; www.DiclegisImportantSafetyInfo.com

view all 10,983 comments

Imoumaima @youssefchorfi

flawlessfashionstore Idk if shes getting paid for this and do not care. But it is safe for mom & baby. I called my doctor because I couldn't even keep water down.

Add a comment...

Patient health outcomes may improve if patients are fully involved in understanding their treatments and their illness, and in managing their own treatments to a greater extent. We are moving beyond informed consent to a more robust model of "patient engagement", "shared decisionmaking", and "activation".

► Quality of care may improve when patients are engaged in their own care.

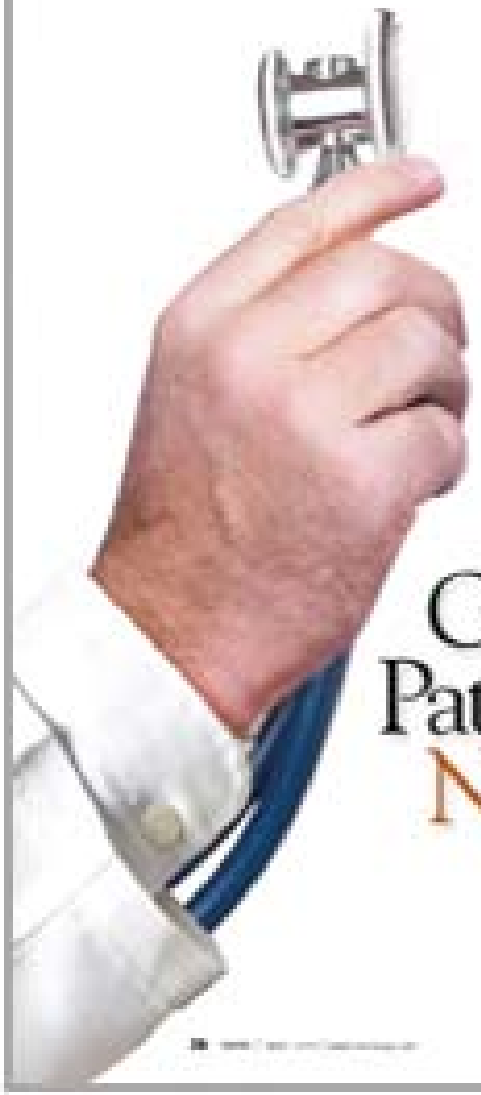
► Patient "voice" may be enhanced if patients are listened to and allowed wider ranges of choices in tough cases.

►Costs may be reduced if patients made more informed health care choices, were better able to manage their own conditions, and adopted healthier lifestyles.

CONCLUSION. PROVIDERS NEED TO INCORPORATE SHARED DECISIONMAKING — DECISION AIDS, CONVERSATIONAL PROCESSES, AND SO ON — INTO THEIR RELATIONSHIPS WITH PATIENTS.

***Gen1* is obsolete. How does the law promote the new and improved versions of shared decisionmaking?**

Medical standards of care, existing legal doctrines, and health care institutional practices will have to change.



After decades of slow acceptance, **shared decision-making** is becoming a pivotal part of the transition to a value-driven delivery system.

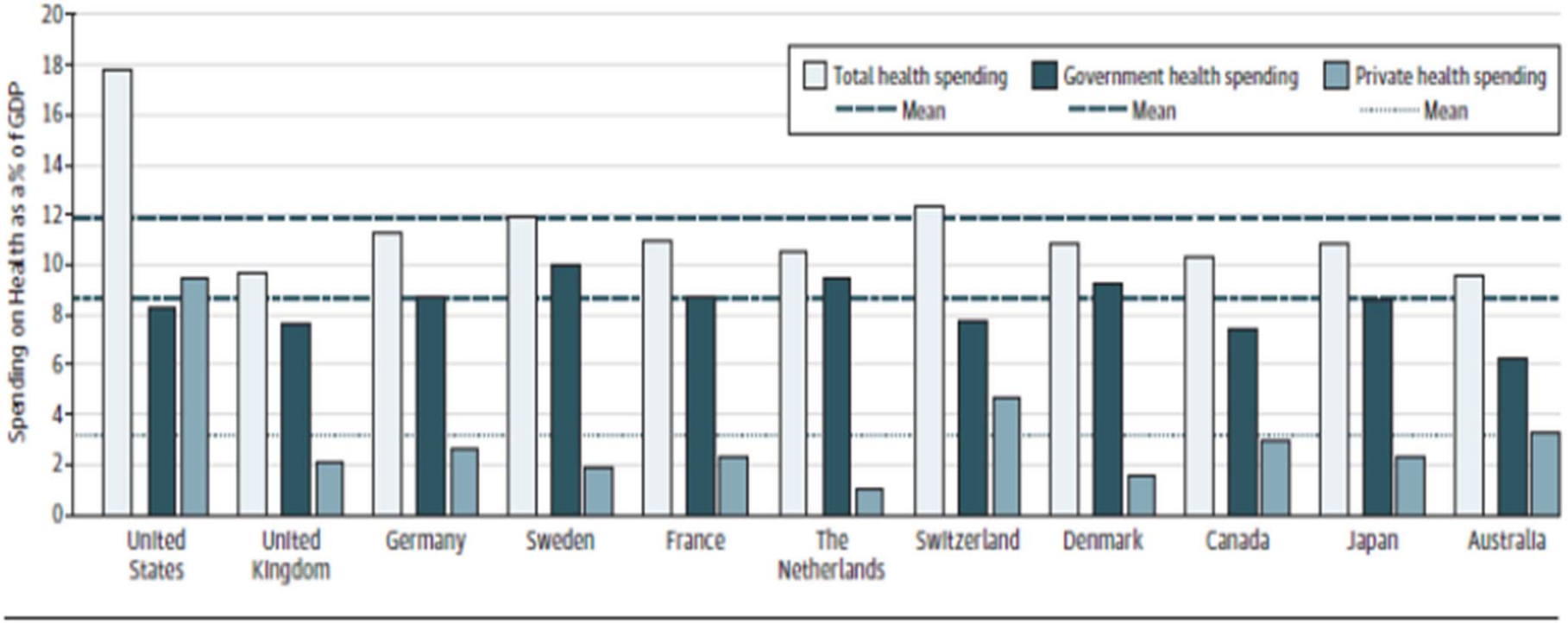
Giving the Patient a Say. No, Really.

BY LOLA BUTCHER

CHOICE II:

Shopping Based on Cost

Figure 2. Health Spending as a Percentage of Gross Domestic Product



Irene Papanicolas, Liana Woskie, and Ashish K. Jha, Health Care Spending in the United States and Other High-Income Countries, 319 JAMA 1024 (2018)

Americans Say More Free-Market Competititon is Better Way to Provide High Quality, Affordable Health Care

Which is the better way to sustainably provide high quality and affordable health insurance to people?
(1) More government management of insurance companies, doctors, and hospitals; OR, (2) More free market competition among insurance companies, doctors, and hospitals

CATO INSTITUTE/YOUGOV FEB 22-23 2017
Response options randomized; Don't Know/Refused 6%

I. SHOPPING FOR CARE BASED ON COST.

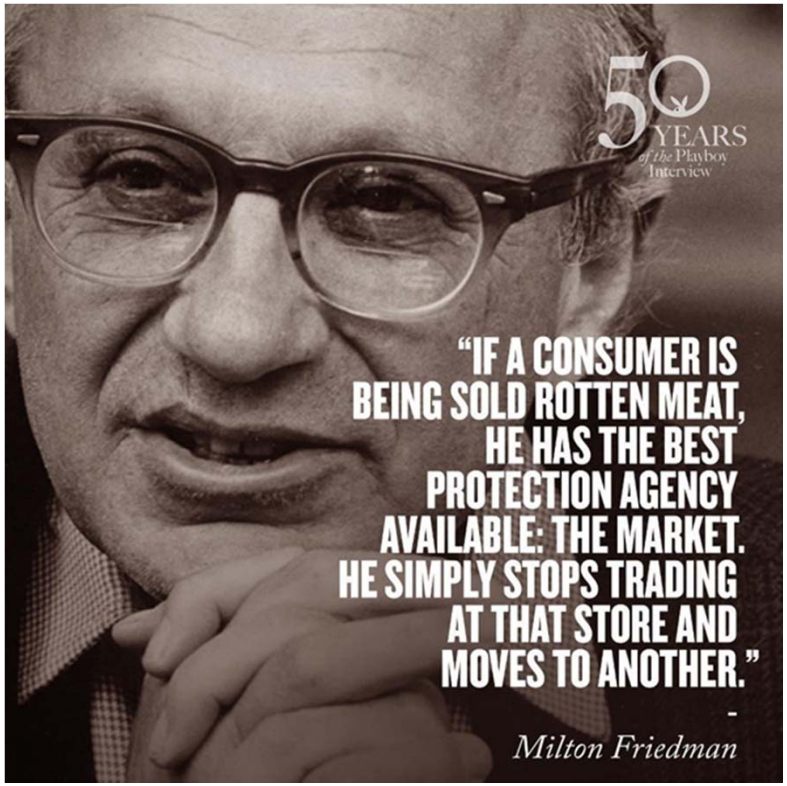
A. WILL A MARKET BLOSSOM?

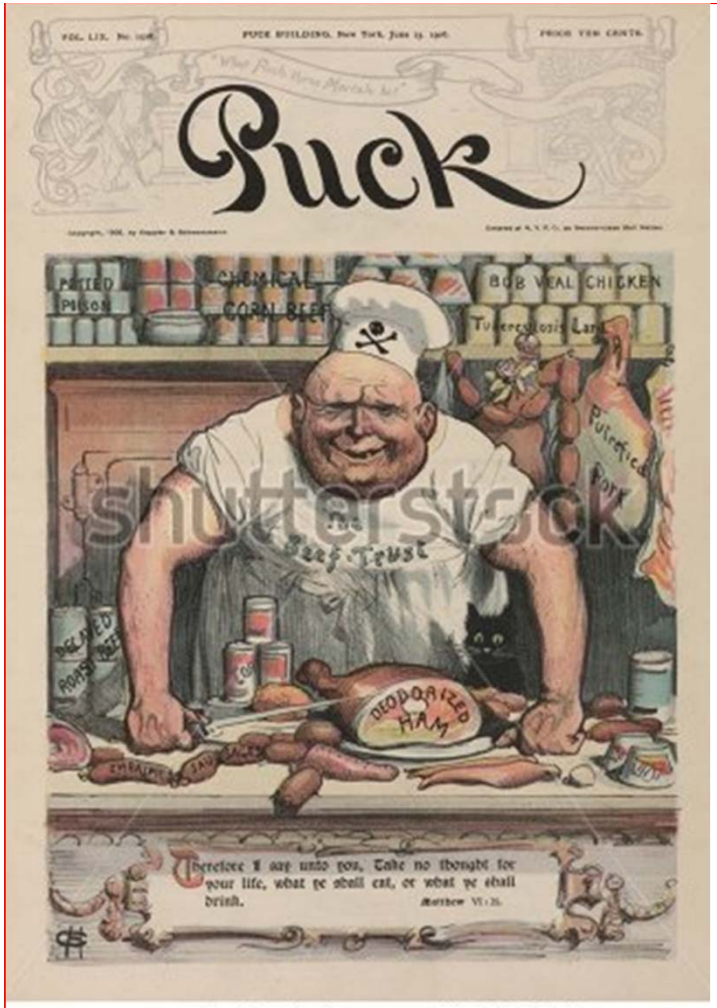
To repeat our assumption: as consumers we can engage in rational decision making and wisely choose among services and products.

How? By shopping for services and products that give good value (low risk, high quality and low price).

We are desperate to lower our costs individually and nationally.

Some argue that we should let the market blossom, just as we do with other consumer goods.
If we shop wisely, suppliers of health care will respond competitively by dropping costs and improving quality.





CHOICE has limits in the health care marketplace.

Paul Krugman: "There are, however, no examples of successful health care based on the principles of the free market, for one simple reason: in health care, the free market just doesn't work. And people who say that the market is the answer are flying in the face of both theory and overwhelming evidence."

See Paul Krugman, Patients are not Consumers, N. Y. TIMES, A23 (April 22, 2011), available at http://www.nytimes.com/2011/04/22/opinion/22krugman.html.

For a positive view of patients at least as risk regulators, see Kristin Madison, Patients as Regulators? Patients' Evolving Influence over Health Care Delivery, 31 J. LEGAL MED. 9, 15 (2010),

COUNTRY RANKINGS

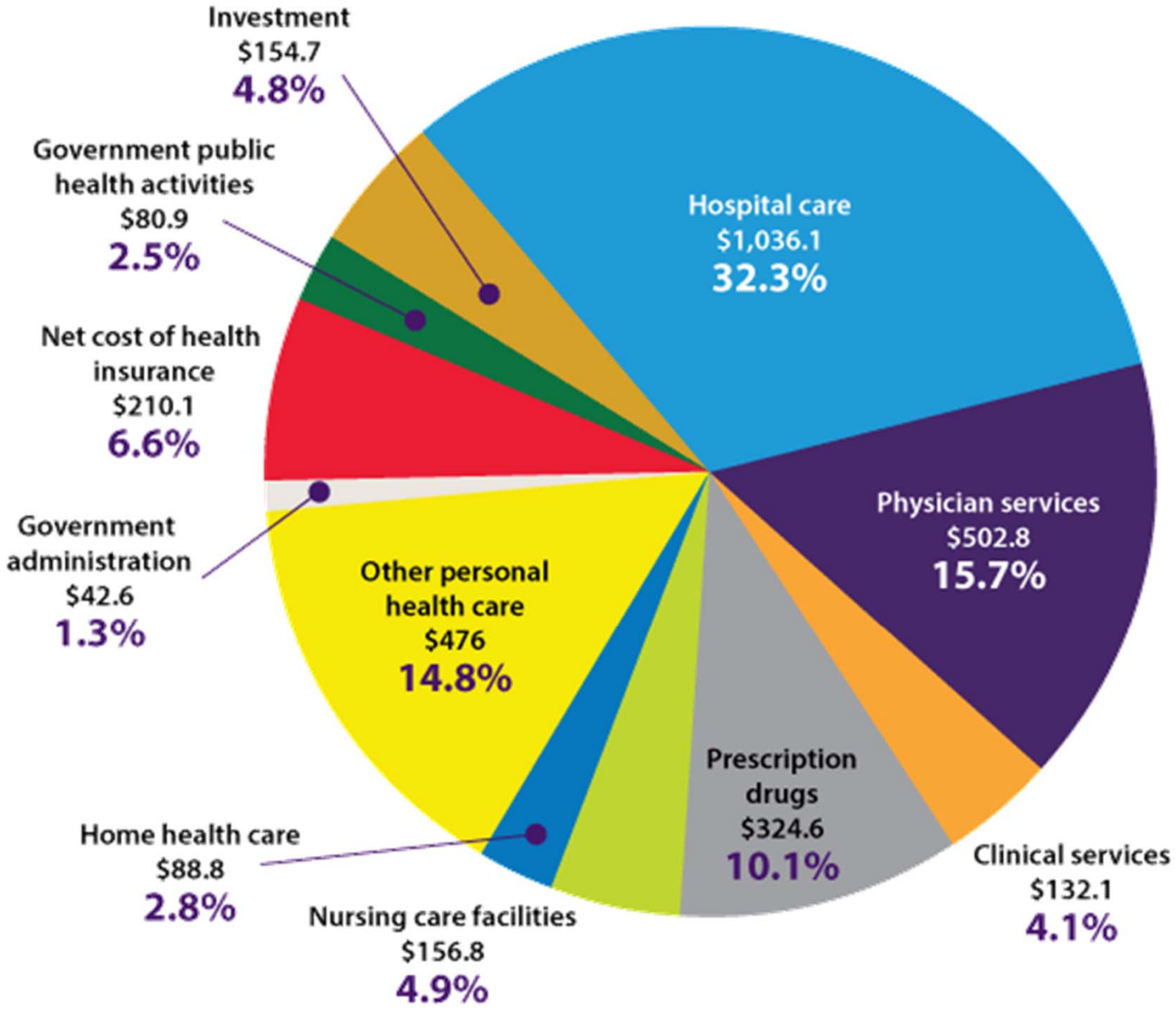
Top 2*
Middle
Bottom 2*

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**	$3,800	$4,522	$4,118	$4,495	$5,099	$3,182	$5,669	$3,925	$5,643	$3,405	$8,508

Notes: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.

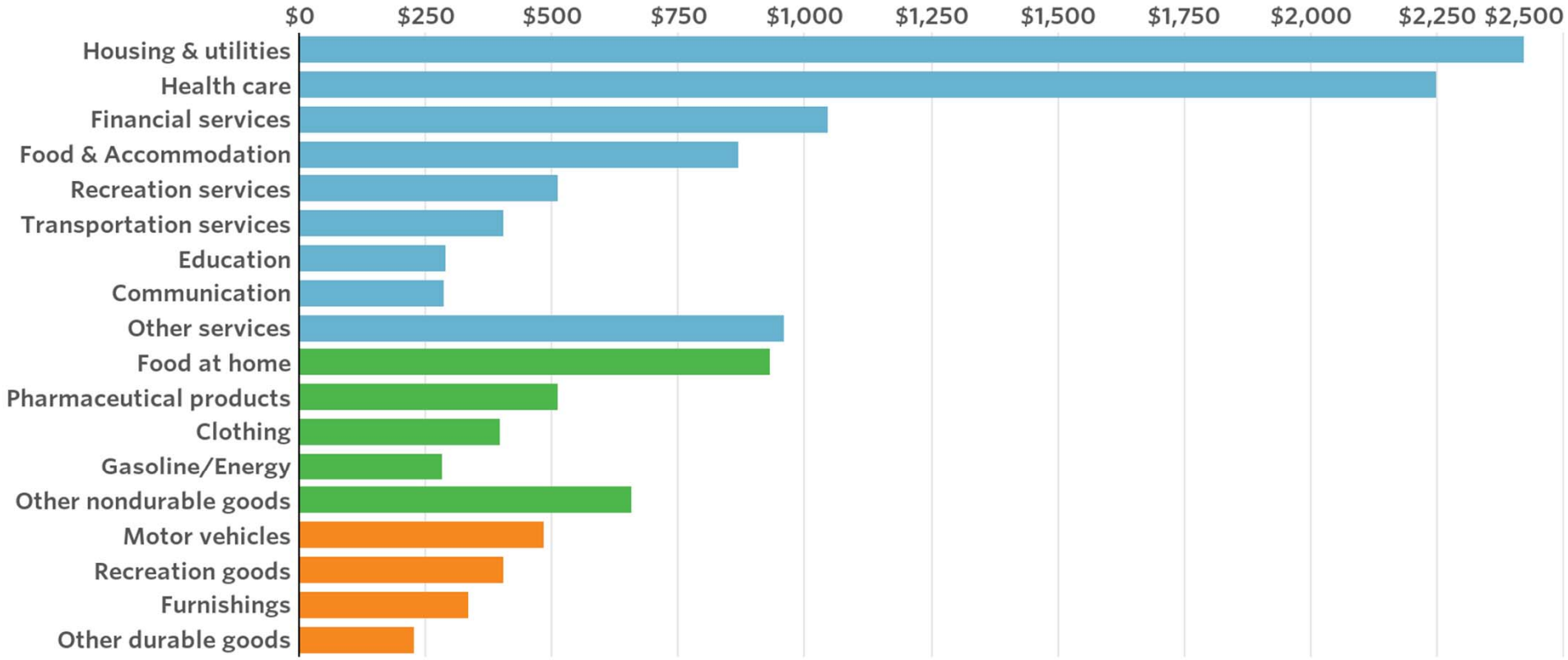
Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund *National Scorecard 2011;* World Health Organization; and Organization for Economic Cooperation and Development, *OECD Health Data, 2013* (Paris: OECD, Nov. 2013).

The U.S. Spent $3,205.6 Billion on Health Care in 2015 Where Did It Go?*



Where the money goes

Top categories for personal consumption expenditures

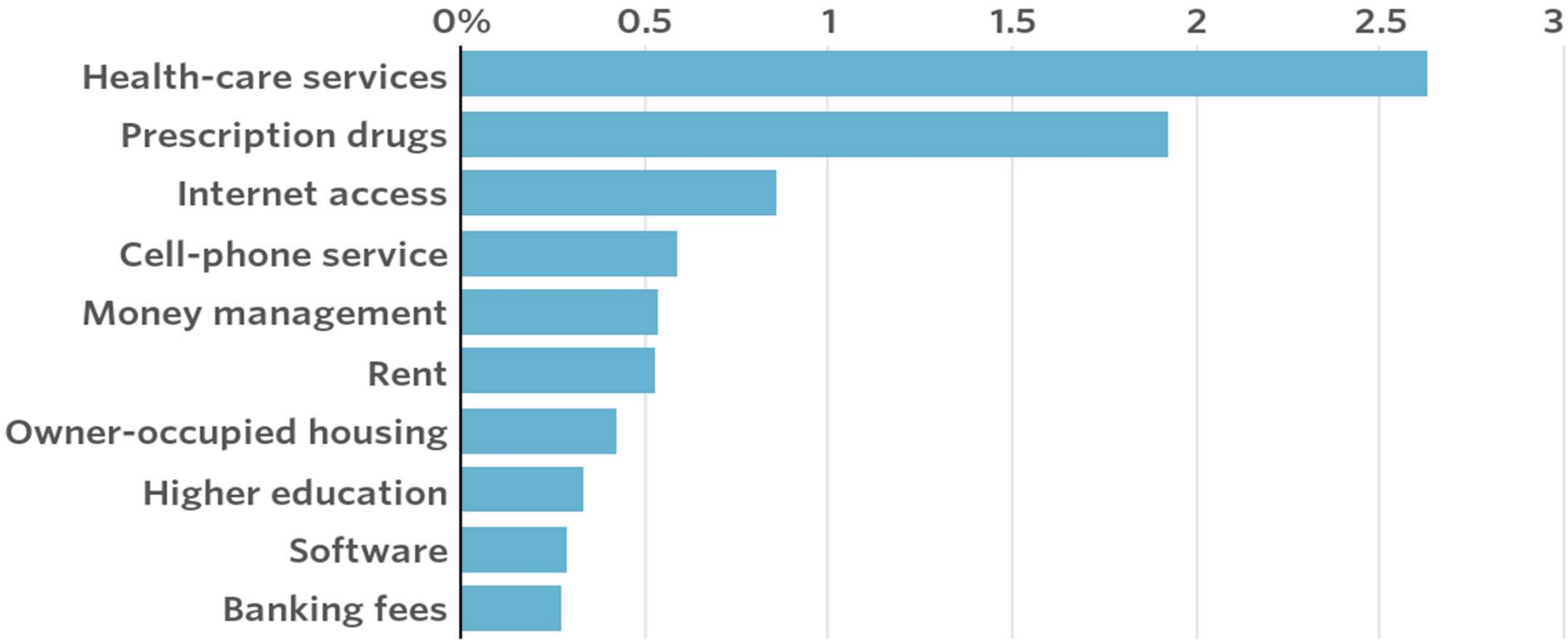


Note: Seasonally adjusted annual rate, in billions of dollars, as of 2017 second quarter. Blue bars are services, green bars are nondurable goods, and orange bars are durable goods.

Source: BEA

Growing share of spending

Greatest percentage change in share of spending 1997-2017



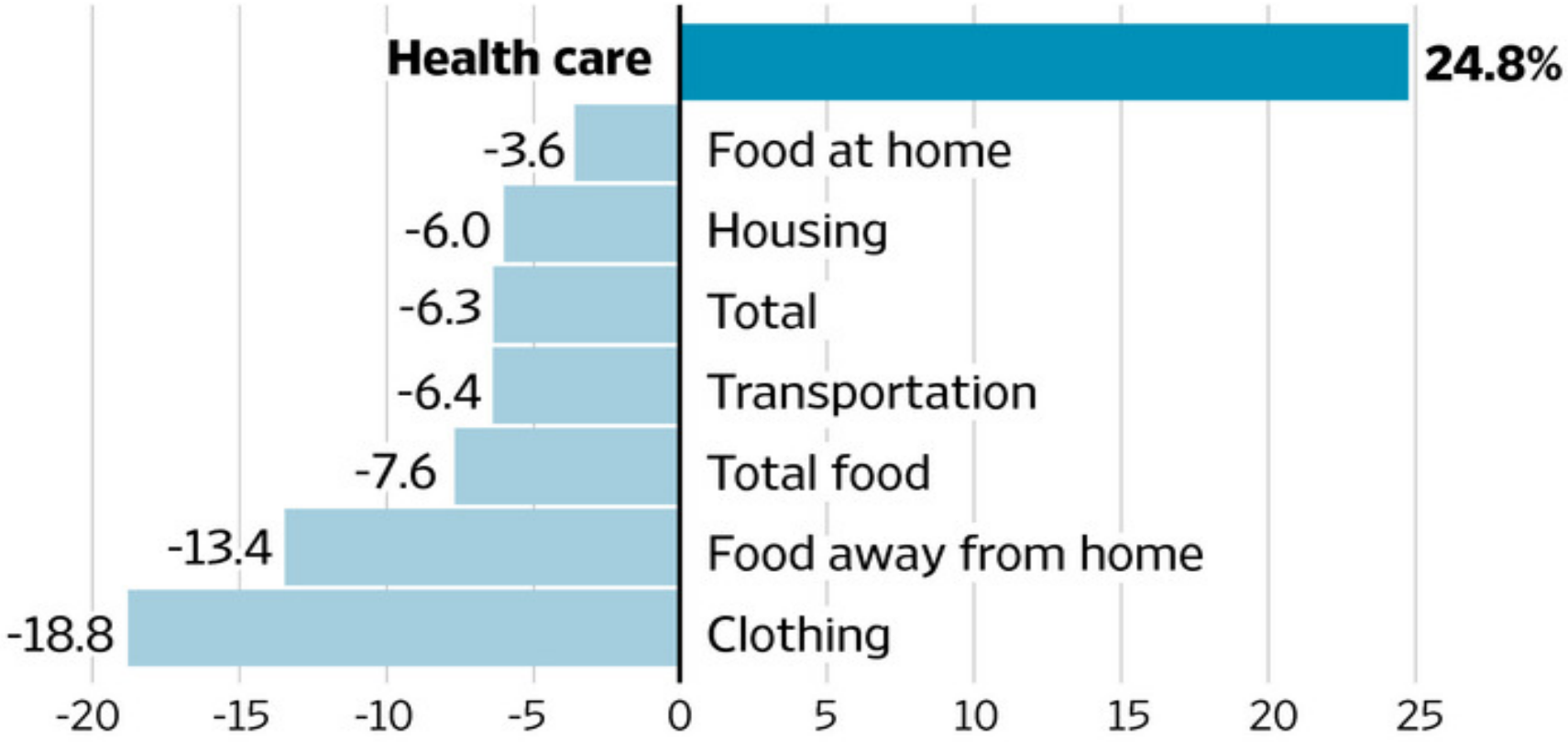
Note: These categories had the largest increase from 1997 to 2017 in relative share of consumer spending. For instance, health-care services accounted for 14.3% of spending in 1997, and 16.9% in 2017.

Source: BEA

A Bigger Bite

Middle-class families' spending on health care has increased 25% since 2007. Other basic needs, such as clothing and food, have decreased.

Percent change in middle-income households' spending on basic needs (2007 to 2014)



Sources: Brookings Institution analysis of Consumer Expenditure Survey, Labor Department

THE WALL STREET JOURNAL.

B. CONSUMERISM IN HEALTH CASE IS FORECAST BY INDUSTRY

- **"More wired, consumer-oriented and innovative than ever before, the $2.8 trillion US health care industry is undergoing profound transformation," writes PWC.**
- **"In 2015, the...sector will begin to look and feel like other industries, catering to customers expecting one-click service. A true consumer-driven market is slowly taking shape.“**
- **What does this mean for the practice of medicine? Is it all to the good?**

How Consumers Purchase Healthcare

50% GROWTH
expected in clinics
in the next 5 years

SHOPPABLE PROCEDURES

"I need to have a procedure done, but it's not urgent. Where do I go?"

- Diagnostic procedures
- Surgical procedures
- Therapeutic procedures

Estimated market size:
$700 BILLION

EMERGENT CARE

"I have an injury or illness that must be addressed immediately"

- Low- to mid-acuity urgent care
- Emergency Care

Projected alternative emergent care site revenue, 2020:
$40 Billion

ENHANCED MANAGEMENT

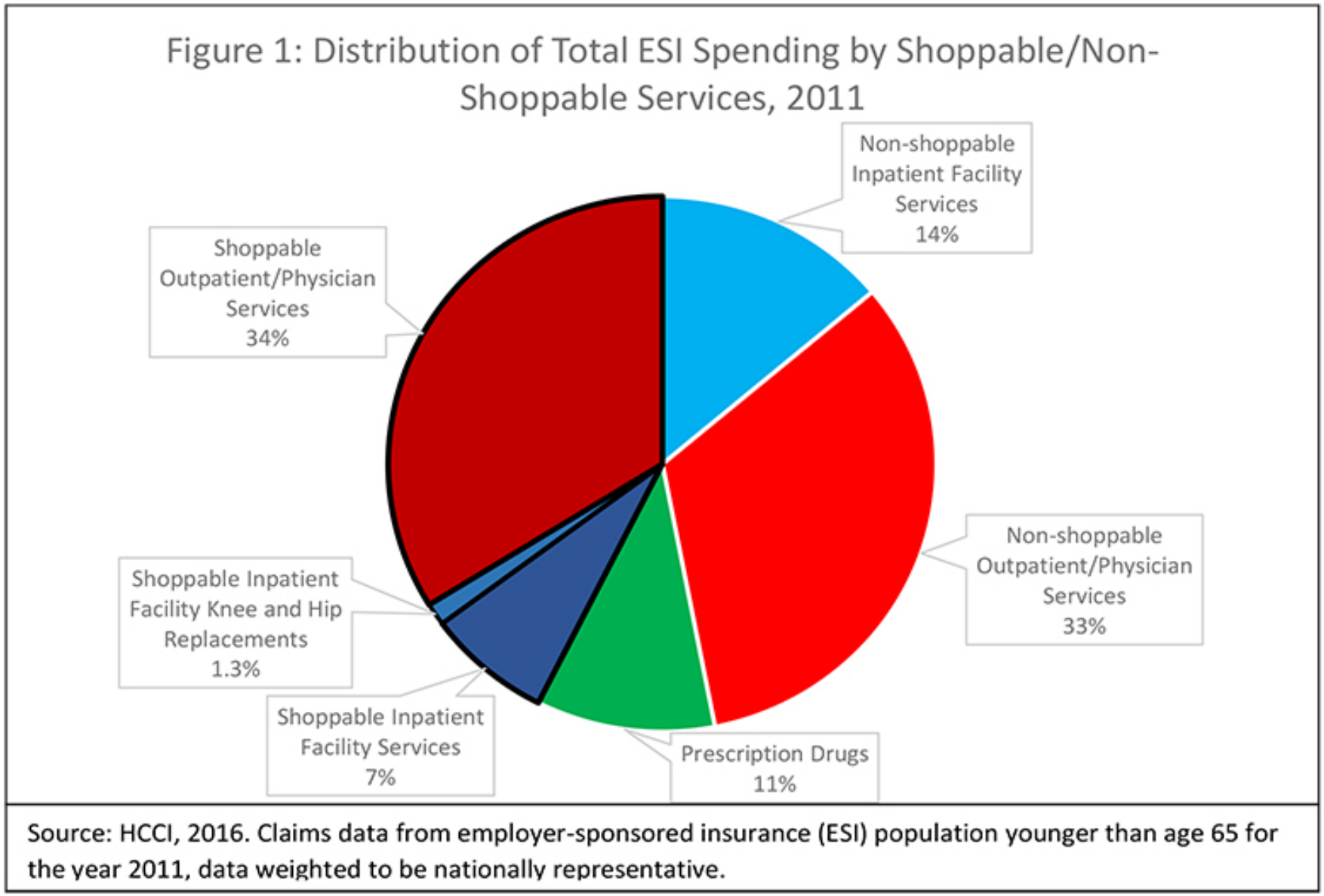
"I want a relationship with a provider to manage my ongoing health needs"

- Preventative care
- Lifestyle management
- Chronic disease management

Projected annualized growth rate:*
10%

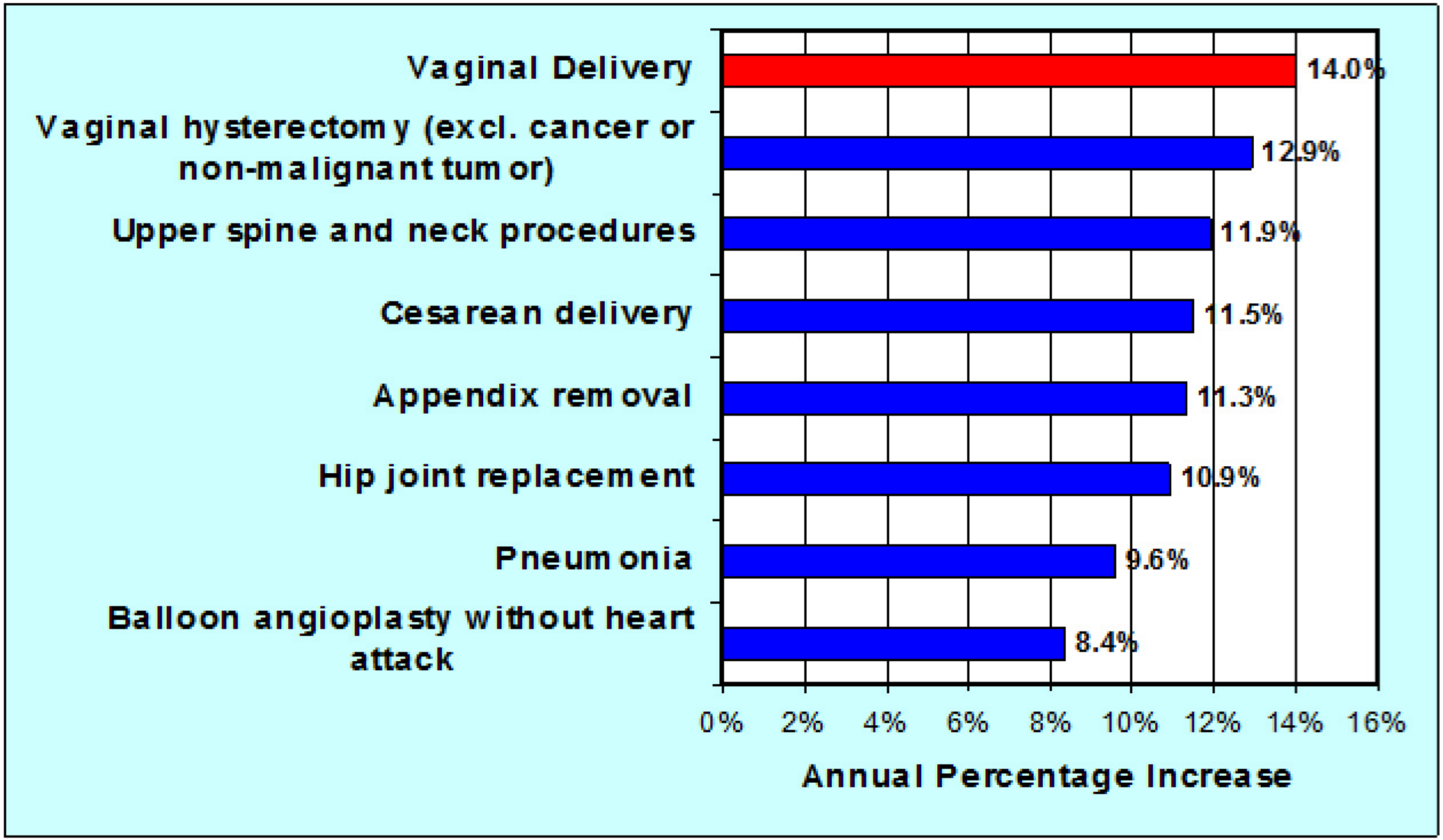
*vs. 4% for primary care

C. THE LIMITS OF CONSUMER SHOPPING IN HEALTH CARE

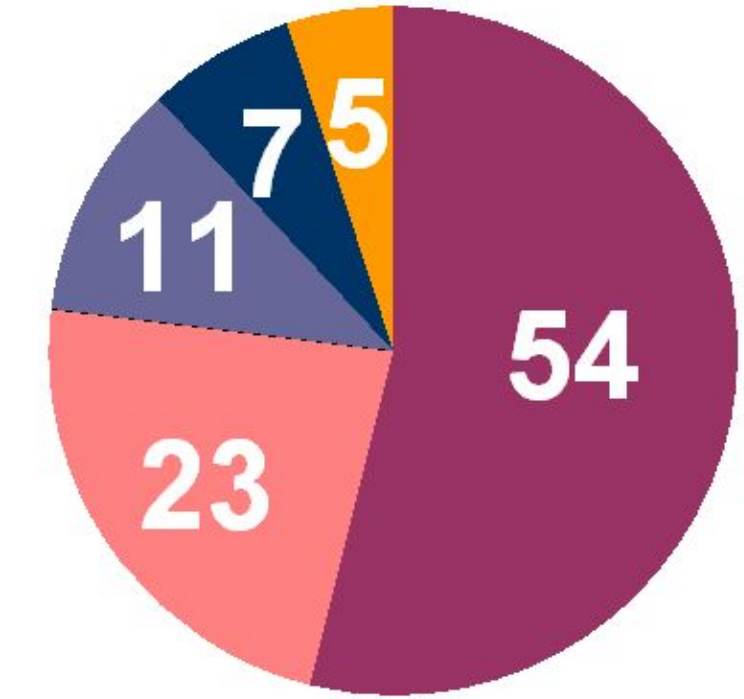


Source: HCCI, 2016. Claims data from employer-sponsored insurance (ESI) population younger than age 65 for the year 2011, data weighted to be nationally representative.

CONSUMER CHOICE MEANS THE ABILITY TO SHOP FOR HEALTH CARE GOODS AND SERVICES BASED ON BOTH QUALITY AND PRICE. HOW?



Would You Price Shop for Treatment



HESITATION:

30% Quality of Care

21% Happy w/ current Dr

13% Price Not Everything

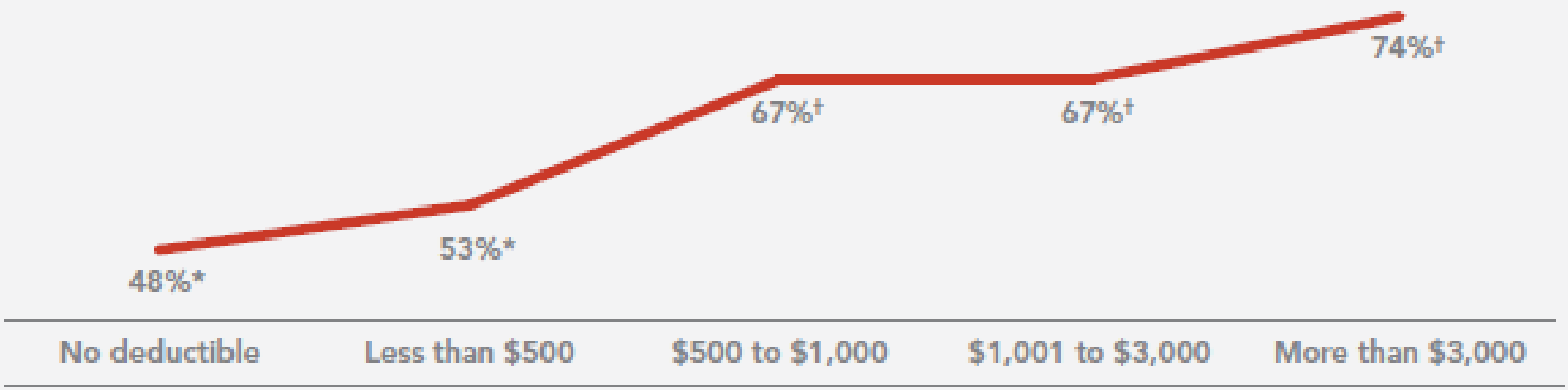
13% Specific situation

9% Consumer burden

8% Use recommendations

People with deductibles over $500 are more likely to seek price information.

Figure 2: Percent who say they have tried to find price information before getting care, by deductible amount:

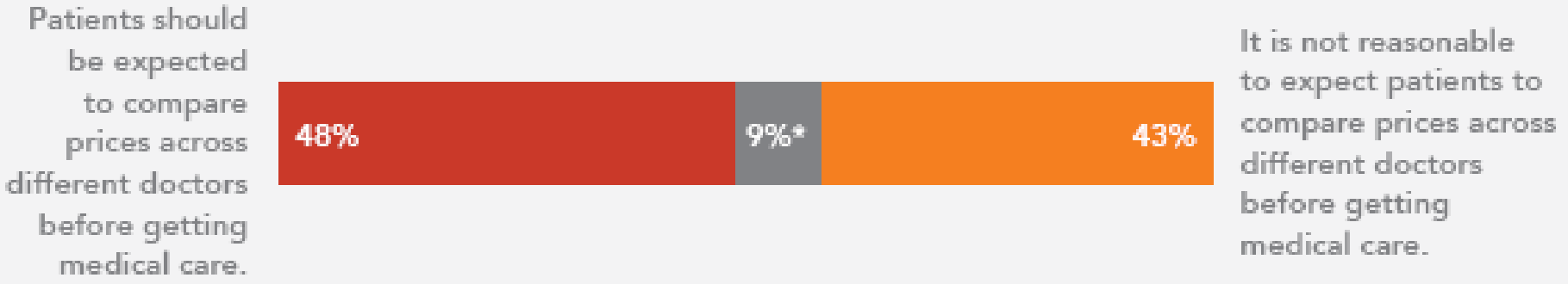


Base: Currently have health insurance, n=1,736.

Estimates for groups indicated by * are not statistically different from each other, and groups indicated by † are not statistically different from each other; groups indicated by * are statistically different from groups indicated by † at the p<.05 level.

Americans are split on whether or not patients should be expected to compare prices before getting care.

Figure 15: Percent who say one of the following statements comes closest to their view:



Base: All respondents, N=2,010.

* Indicates "Don't know" and "refused"

Consumer-based approaches -- price transparency, comparison shopping, retail clinics, and high-deductible health plans featuring health savings accounts -- have severe limits.

Less than 7% of total U.S. healthcare spending in 2011 was paid by consumers for "shoppable" services.

The Health Care Cost Institute concluded that "…the potential gains from the consumer price shopping aspect of price transparency efforts are modest."

Information is hard to find. A secret-shopper study by the Pioneer Institute found that a price of a standard MRI test for the knee, in a survey of 54 hospitals, could not be found in about 25% of the hospitals.

Patients "can't shop for price, even if they wanted to."

PATIENTS *SHOP* FOR HEALTH CARE?

D. Consolidation In Health Care Drives Higher Cost Care

- **"Five years after the Affordable Care Act helped set off a health-care merger frenzy, the pace of consolidation is accelerating, transforming the medical marketplace into a land of giants."***
  - **Payors -- Aetna-Humana, Anthem-Cigna**
  - **Hospitals -- "2015 is on pace to notch the most U.S. hospital deals since 1999, with 71 announced through the end of August"***
  - **Jefferson has just merged with Abington Hospital and soon with Aria Health**

*WSJ 9/21/2015

CONCENTRATION IN HEALTH CARE MARKETS MAKES THE IDEA OF CONSUMER SHOPPING TO REDUCE PRICES A JOKE.*

Prices in the private sector are out of control. On average, private insurers pay 25 percent more than Medicare for physician services and 30 percent more for hospital care. What's more, both public and private sector payment rates for doctors in America are far and away the highest in the world, and research suggests that these high rates are among the principal reasons health care is so much more expensive in this country than elsewhere.

***Diane Archer, No Competition: The Price Of A Highly Concentrated Health Care Market, Health Affairs Blog, March 6, 2013.DOI: 10.1377/hblog20130306.028873**

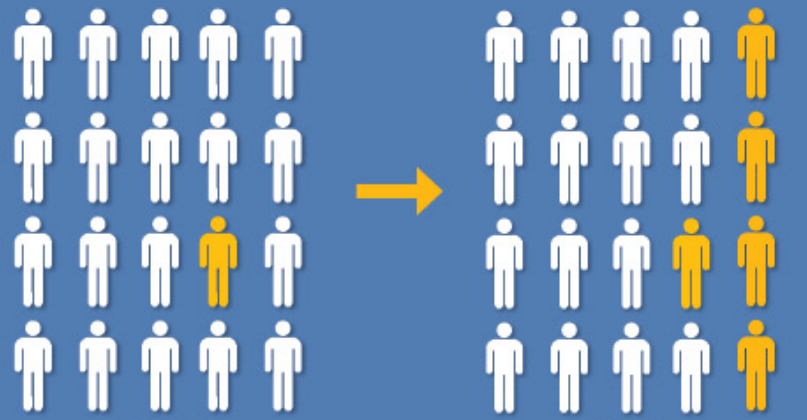
Provider Consolidation
LESS COMPETITION AND HIGHER COSTS

Research demonstrates that when hospitals consolidate, either merging with other hospitals or buying up physician practices, health care costs go up. Provider consolidation gives hospitals greater negotiating strength and limits competition, resulting in higher prices for services, higher costs for patients, and no improvement in the quality of care delivered.

Physicians Are Becoming Hospital Employees[1]

In 2000 1 in 20 specialists was a hospital employee...

...Today 1 in 4 specialists is a hospital employee.

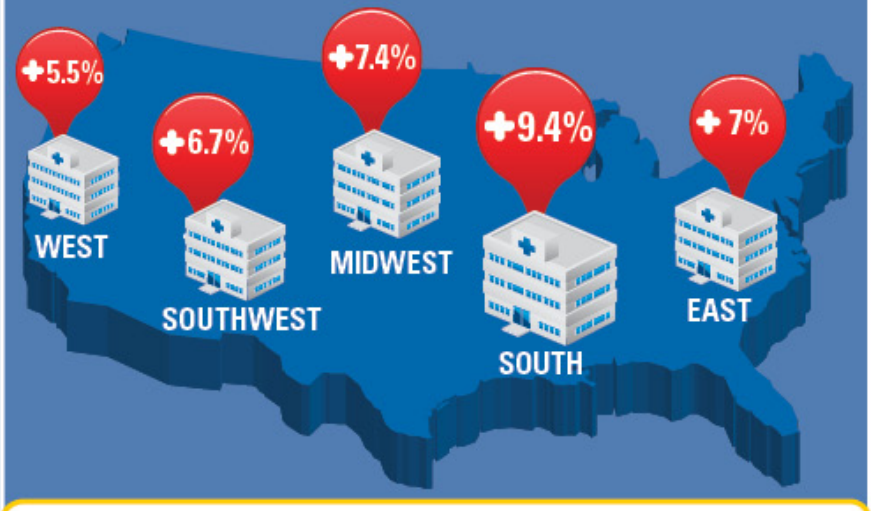


"Last year, a 15-minute visit to a doctor in private practice cost $69...That same visit to a hospital-employed physician cost $124."

-Orlando Sentinel

Increasing Market Concentration Leads to Higher Prices for Consumers[2]

Percentage increase in market concentration from 1999-2003.



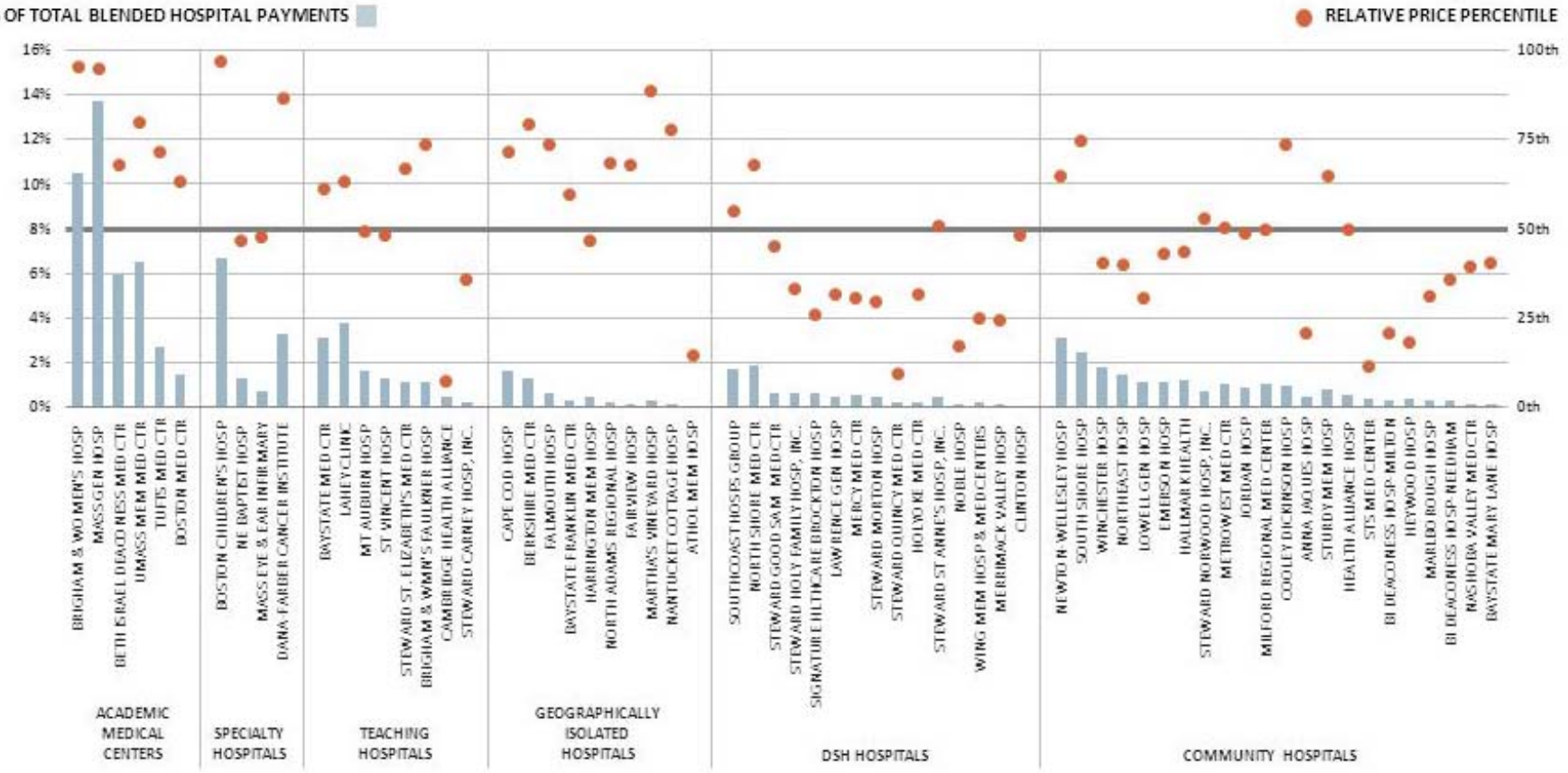
"Research suggests that hospital consolidation in the 1990s raised prices by at least five percent and likely significantly more. Prices increase 40 percent or more when merging hospitals are closely located."

-Robert Wood Johnson Foundation

1. Jameson, Marni. "As Hospitals Take over Doctors' Practices, Fees Rise." Orlando Sentinel. N.p., 15 Sept. 2012. Web. <http://articles.orlandosentinel.com/2012-09-15/health/os-hospitals-buy-physicians-20120915_1_hospital-executives-hospital-employee-physician-practices?pagewanted=all>.
2. Vogt, William B., Ph.D., and Robert Town, Ph.D. How Has Hospital Consolidation Affected the Price and Quality of Hospital Care? Rep. N.p., Feb. 2006. Web. <http://www.rwjf.org/content/rwjf/en/research-publications/find-rwjf-research/2006/02/how-has-hospital-consolidation-affected-

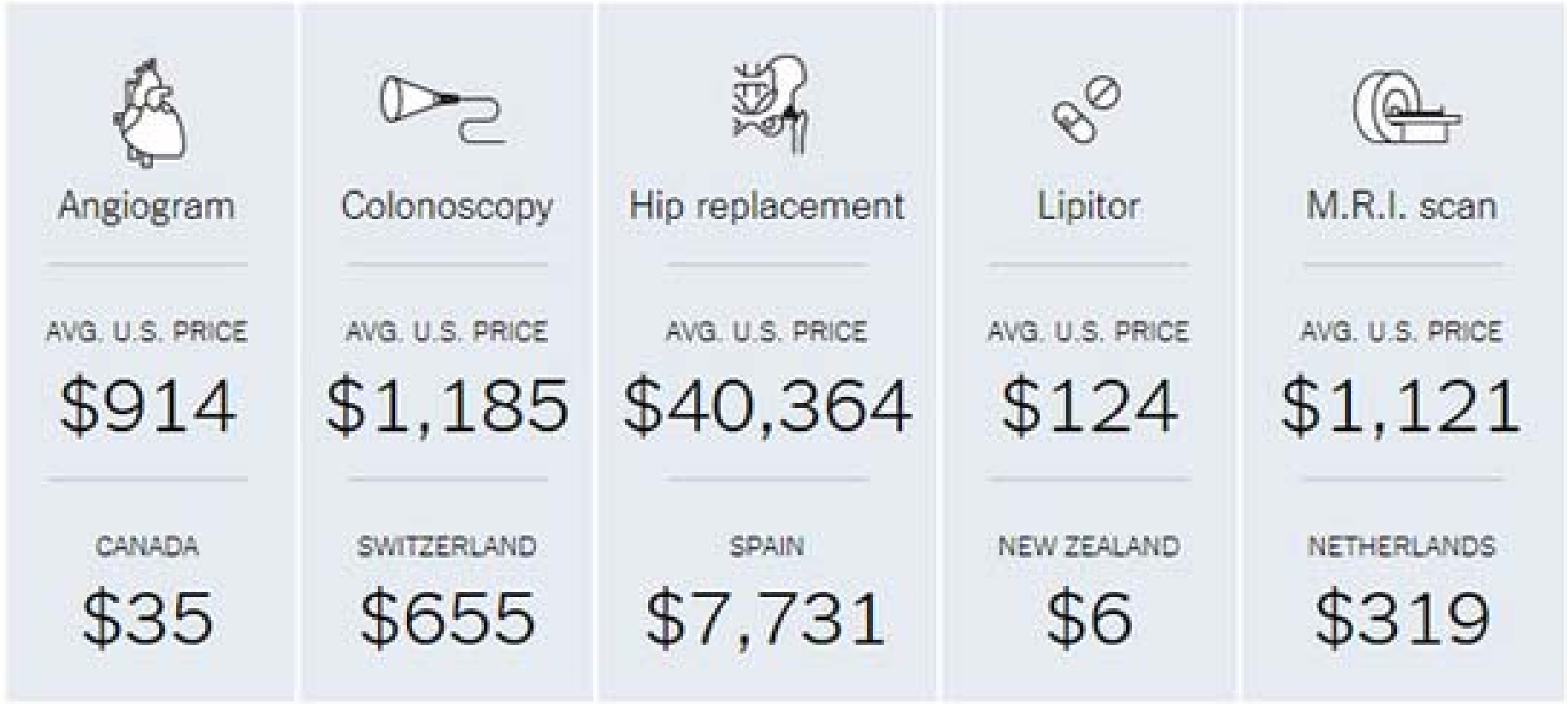
Prices Are Likely Driven by the Different Market Power or Bargaining Power of Different Hospitals, As Hospitals With Greater Market Share Tend to Command Higher Prices

RELATIVE PRICES AND HOSPITAL MARKET SHARE OF TOTAL BLENDED HOSPITAL PAYMENTS



SOURCE: Center for Health Information and Analysis, "Health Care Provider Price Variation in the Massachusetts Commercial Market," February 2013.

Private payments for an office visit in the United States cost 70 percent more than those abroad, while public payments are 27 percent higher. Prices are largely set by insurers and providers with monopoly power to maximize profits. Big hospital chains and provider groups dominate most local markets and extract extremely high rates from dominant insurers, which are motivated by fear of losing market share if they fail to attract these providers to their networks.

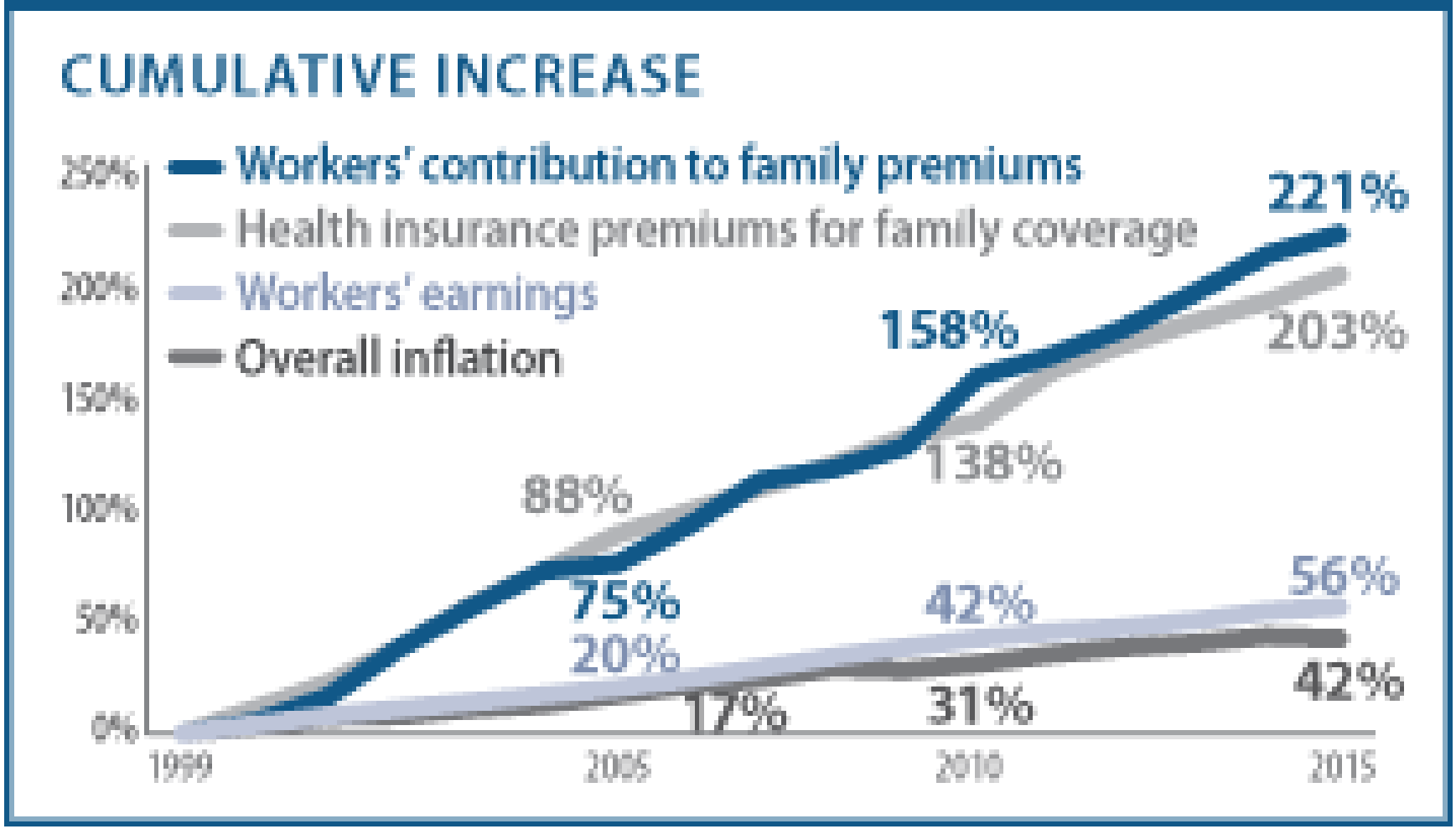


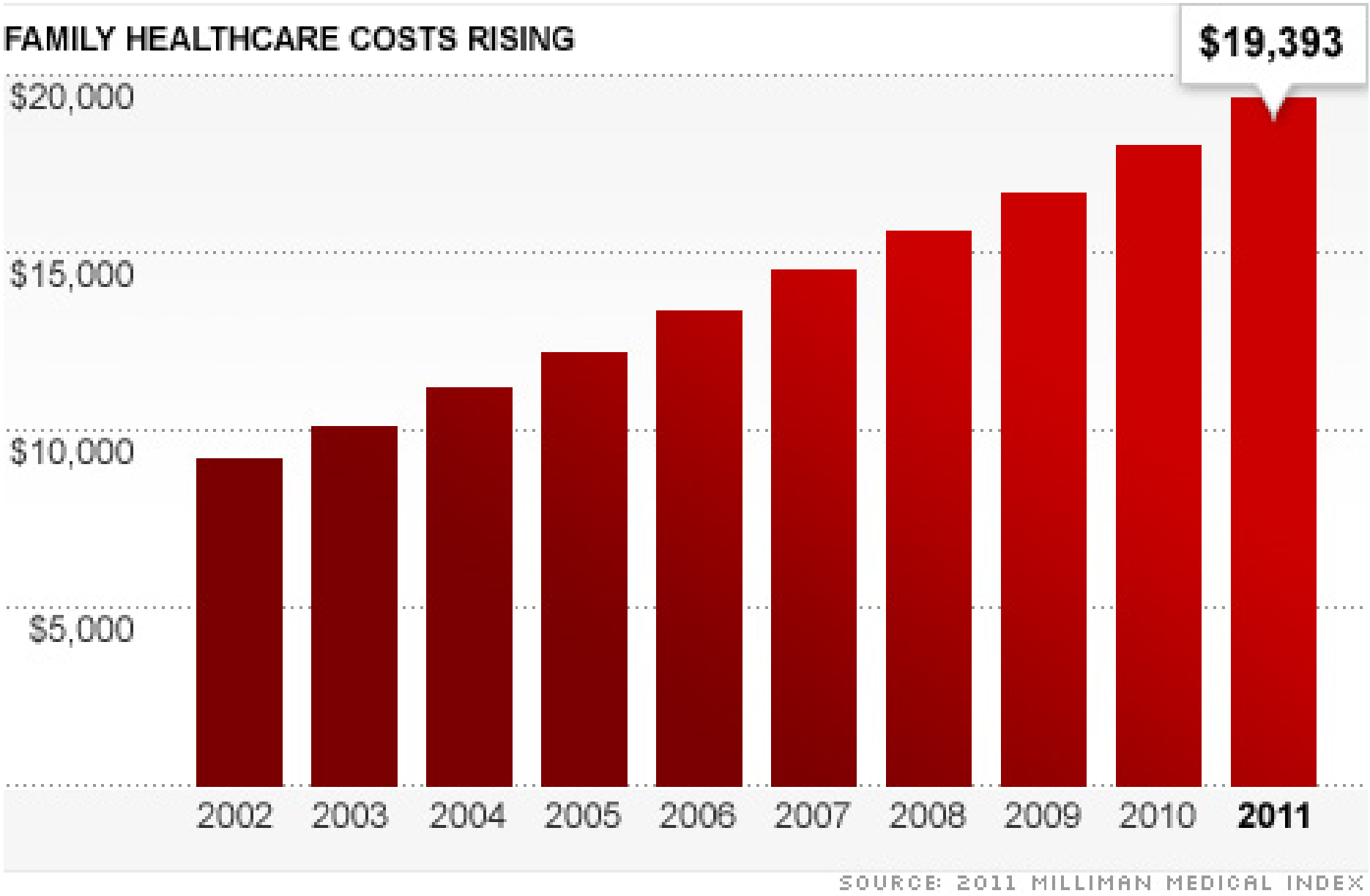
Source: 2012 Comparative Price Report by the International Federation of Health Plans. The average prices shown for colonoscopies do not include added fees for sedation by an anesthesiologist, a practice common in the United States, but unusual in the rest of the world. The additional charges can increase the cost significantly.

Source: New York Times

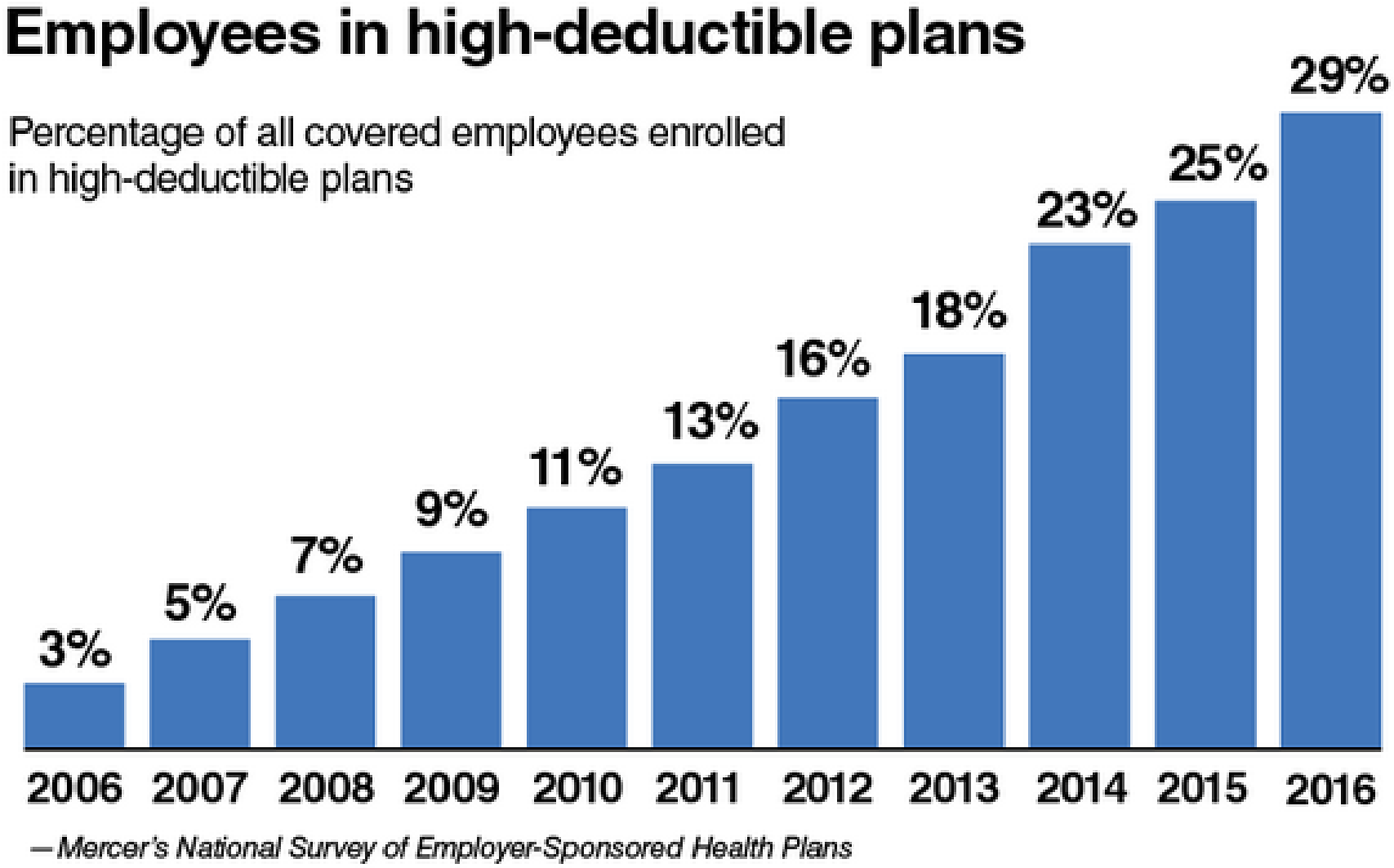
CAN "SKIN IN THE GAME" HELP IN THE FACE OF MARKET CONCENTRATION AND ITS POWER TO DRIVE PRICES??

RECENT TRENDS IN EMPLOYER-SPONSORED HEALTH INSURANCE PREMIUMS




FAMILY HEALTHCARE COSTS RISING
$19,393
$20,000
$15,000
$10,000
$5,000
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
SOURCE: 2011 MILLIMAN MEDICAL INDEX

CONSUMER-DIRECTED HEALTH PLANS



HSA High Deductible Health Plan (HDHP) - 2017 Guidelines

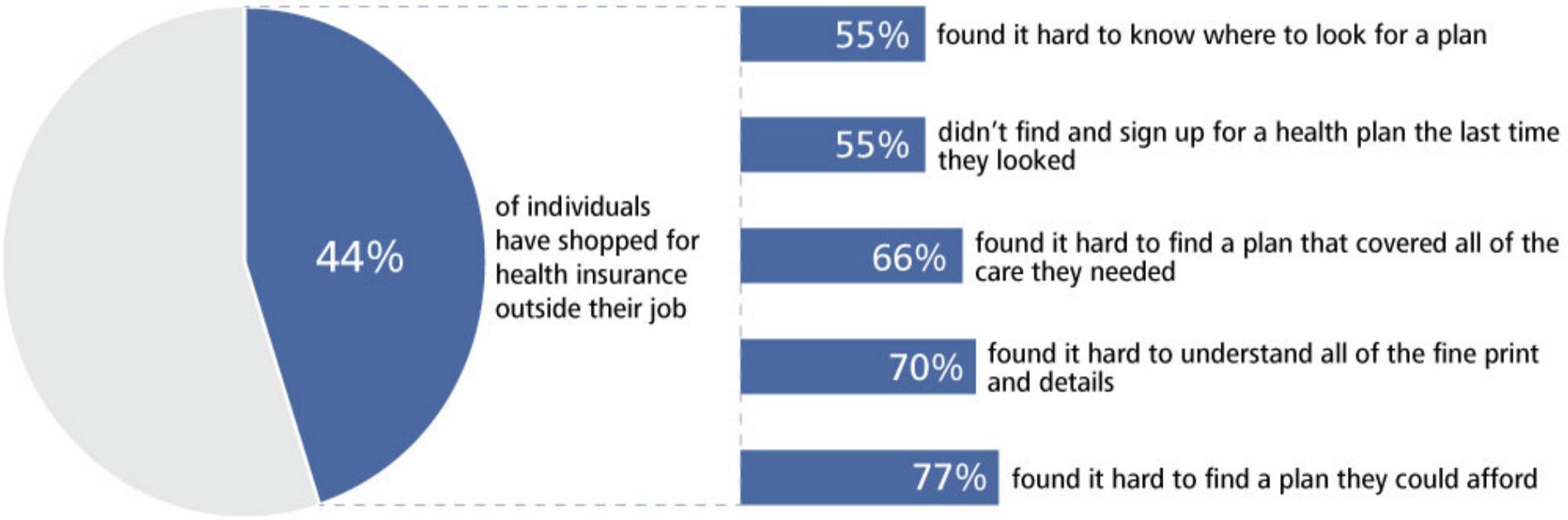
To be considered a HDHP (and to qualify for opening an HSA), the HDHP must meet the following minimum annual deductible and maximum annual deductible and other out-of-pocket expenses for HDHPs for 2017.

	Self-only coverage	Family coverage
Minimum annual deductible	$1,300	$2,600
Maximum annual deductible and other out-of-pocket expenses*	$6,550	$13,100

* This limit does not apply to deductibles and expenses for out-of-network services if the plan uses a network of providers. Instead, only deductibles and out-of-pocket expenses for services within the network should be used to figure whether the limit applies.

A CONSUMER DREAM COME TRUE—FOR THE TOP 1% (AND LAYWERS!)

Figure 1. Many people have low awareness of insurance terms and processes, and question health plans' affordability.



Source: Lake Research Partners and Inform America, *Informing Enroll America's Campaign: Findings from a national study*, January 2013, p. 9, https://s3.amazonaws.com/assets.enrollamerica.org/wp-content/uploads/2013/11/Informing-Enroll-America-Campaign.pdf. N = 1,814 adults ages 18 to 64 at or below 400 percent of the federal poverty level.

Graphic: Deloitte University Press | DUPress.com

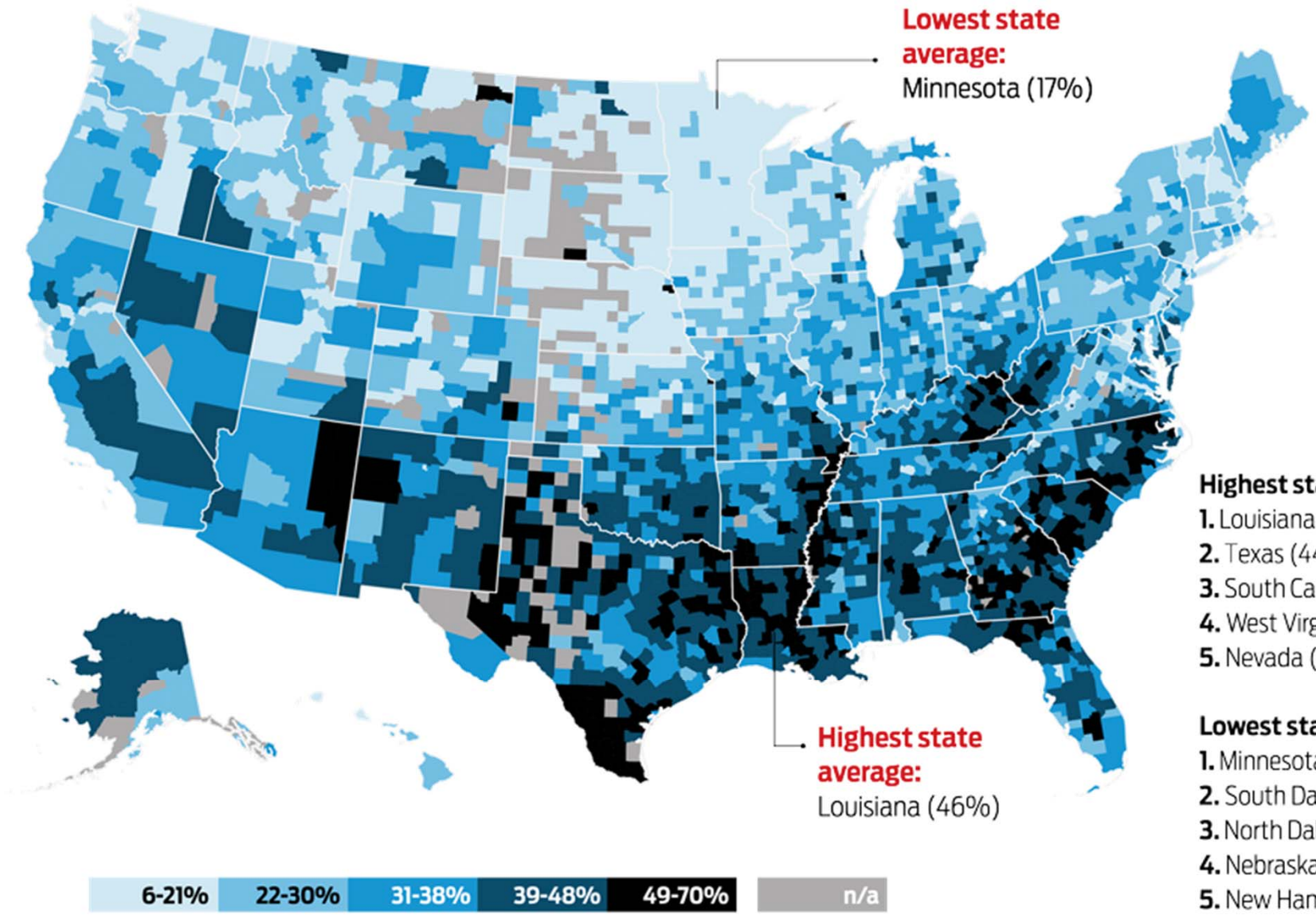
HEAVY BURDEN FOR MOST. **Lower monthly premiums tradeoff coverage for the payment of much more out-of-pocket before your insurance begins to cover your bills. Individuals are paying an average $2,295 before insurance kicks in and families are ponying up $4,364 on average, according to the Kaiser Family Foundation.**

COST-SHIFTING TO EMPLOYEES. EMPLOYERS SHIFT COSTS. **That's a big deal, because more than half of Americans get health insurance through their employer.**

HIGH-DEDUCTIBLE PLANS WILL BECOME THE ONLY CHOICE FOR MANY. **Within three years, almost 40 percent of companies that offer health insurance may make the move. In 2012, it was just 13 percent.**

CARE IS POSTPONED FOR MOST, AS THE HIGH DEDUCTIBLES SINK IN. PATIENTS END UP SICKER AND POORER….OR IN BACKRUPTCY. **A 2015 survey found that almost 30% of people with deductibles higher than $ 1,500 for individual coverage avoided medical care—tests, treatments, follow-up-care, and prescription drugs—because they couldn't afford the out-of-pocket costs. CONSUMERS DO NO MORE PRICE SHOPPING FOR MEDICAL SERVICES THAN THE AVERAGE PERSON, AND FAIL TO USE FREE PREVENTIVE SERVICES.**

Where Americans Are Falling Behind on Debt

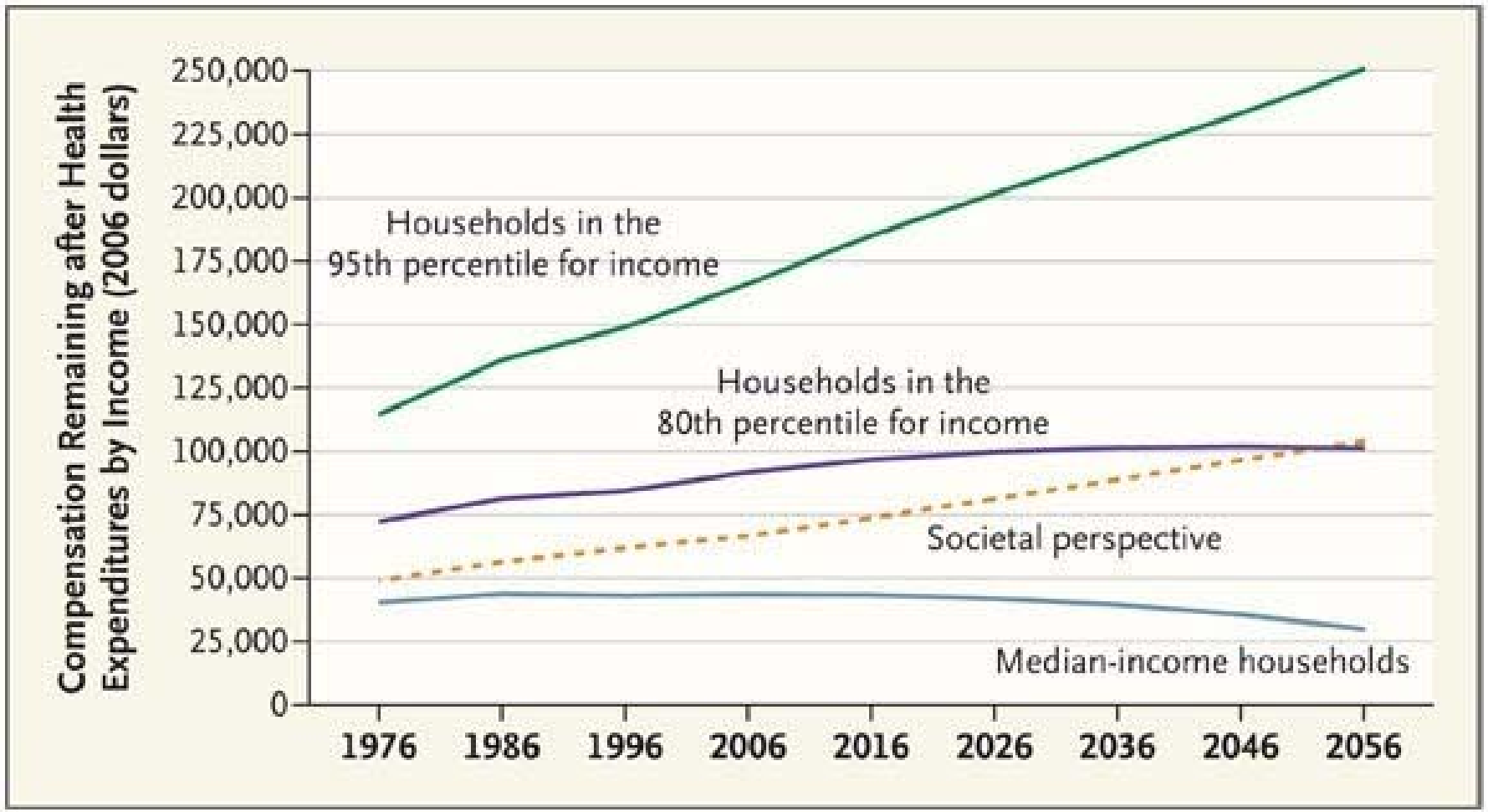


Highest state averages:

1. Louisiana (46%)
2. Texas (44%)
3. South Carolina (43%)
4. West Virginia (42%)
5. Nevada (41%)

Lowest state averages:

1. Minnesota (17%)
2. South Dakota (18%)
3. North Dakota (19%)
4. Nebraska (20%)
5. New Hampshire (22%)


Compensation Remaining after Health Expenditures by Income (2006 dollars)
250,000
225,000
200,000
175,000
150,000
125,000
100,000
75,000
50,000
25,000
0
Households in the 95th percentile for income
Households in the 80th percentile for income
Societal perspective
Median-income households
1976
1986
1996
2006
2016
2026
2036
2046
2056

THE PATIENT AS SHOPPER IS A POOR STRATEGY

KNOWLEDGE ASYMMETRY. The patient-as-consumer faces a knowledge asymmetry almost impossible to overcome. Americans' general deference to physicians isn't just a cultural trait, it simply reflects the expertise and training regarding diagnoses, possible treatments, and likely outcomes doctors possess and their patients do not. For some cases and for some conditions, the layman can narrow that yawning information gap. But WebMD or no, it can't be eliminated.

HEALTH AS A NON COMMODITY. Those who believe that choosing a health care product or service is no different than buying a car, television, or cell phone might feel differently after, say, developing colon cancer.

PRICES ARE LARGELY INVISIBLE OR COMPLETELY OPAQUE. Even if the diagnoses, treatments, and cures for heart disease, diabetes, or depression could be purchased in a free market, in the United States the buyer simply doesn't—or can't—know what price he or she will pay. See Stephen Brill, America's Bitter Pill: Money, Politics, Backroom Deals, and the Fight to Fix Our Broken Health Care System (2015)

CHOICE III:

All-payer Systems

If a centralized rate-setter bands every insurer together to negotiate prices, all payer can functionally act like single payer in terms of bringing down costs. **All payer reduces hospital and insurer overhead, since billing costs are known in advance. France, Germany, Japan, Switzerland, and The Netherlands — all use all-payer rate setting as the basis for their universal health care systems. These countries have been found to control costs far better than America's fragmented system.**

Either a government agency or a panel of private insurers sets one distinct price for every medical procedure.

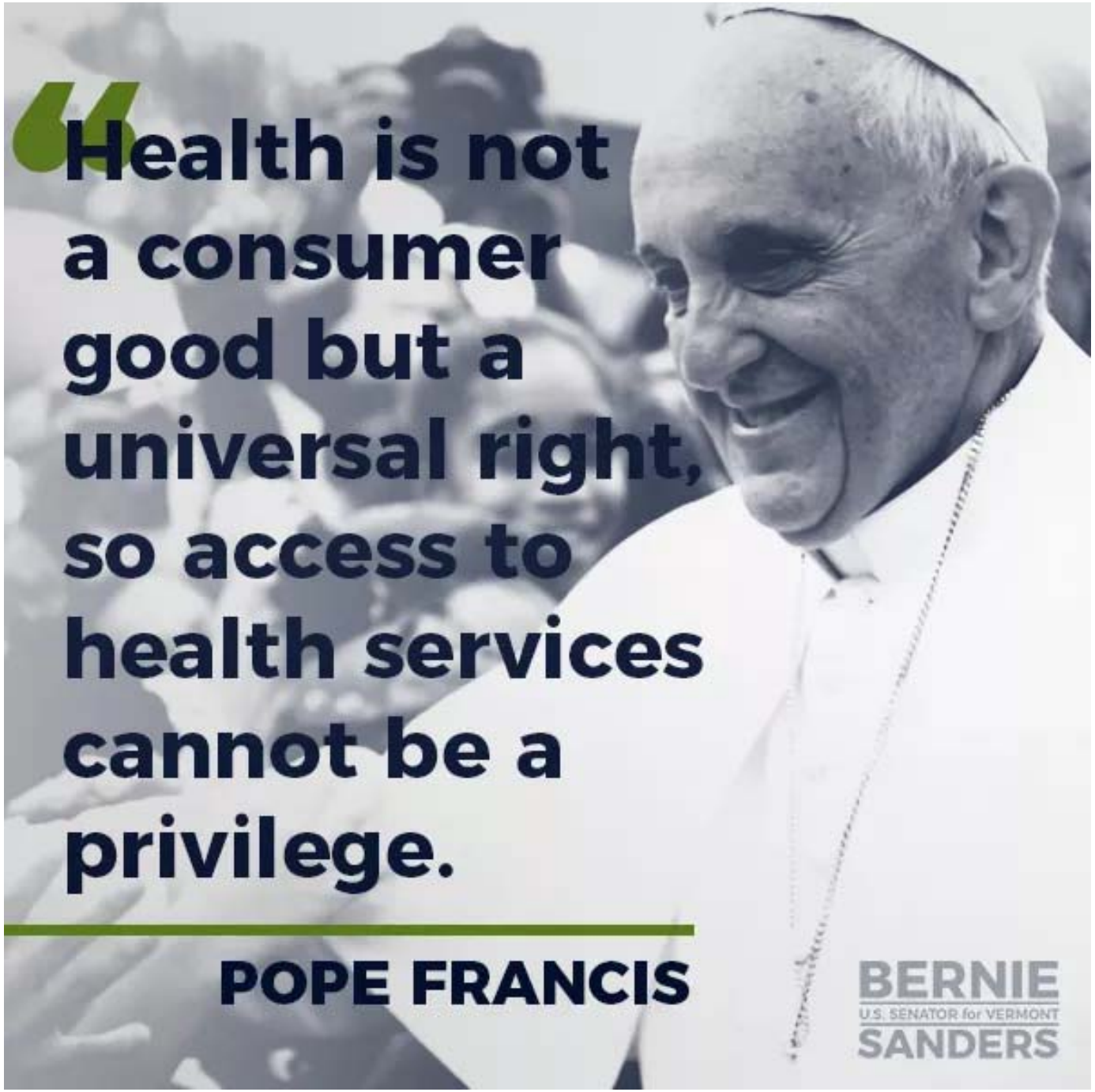
Exhibit 7. Prices for Hospital and Physician Services, Pharmaceuticals, and Diagnostic Imaging

	Total hospital and physician costs, 2013[a]		Diagnostic imaging prices, 2013[a]		Price comparison for in-patent pharmaceuticals, 2010 (U.S. set to 100)[b]
	Bypass surgery	Appendectomy	MRI	CT scan (abdomen)	
Australia	$42,130	$5,177	$350	$500	49
Canada	–	–	–	$97	50
France	–	–	–	–	61
Germany	–	–	–	–	95
Netherlands	$15,742	$4,995	$461	$279	–
New Zealand	$40,368	$6,645	$1,005	$731	–
Switzerland	$36,509	$9,845	$138	$432	88
United Kingdom	–	–	–	–	46
United States	$75,345	$13,910	$1,145	$896	100

[a] Source: International Federation of Health Plans, 2013 Comparative Price Report.
[b] Numbers show price indices for a basket of in-patent pharmaceuticals in each country; lower numbers indicate lower prices.
Source: P. Kanavos, A. Ferrario, S. Vandoros et al., "Higher U.S. Branded Drug Prices and Spending Compared to Other Countries May Stem Partly from Quick Uptake of New Drugs," *Health Affairs*, April 2013 32(4):753–61.

All-payer rate setting -- All the insurers negotiate jointly with all of the health care providers, and set on one specific price for each procedure...
Single-payer health care systems -- Save money in two ways: reducing administrative costs and increasing the bargaining power of health insurers.
This is true of all-payer rate setting systems, too.

Whether in the nationalized system of the UK, the single-payer systems of Canada's provinces, the mandated health savings accounts in Singapore, or the universal coverage regimes dependent on private insurers in France, Germany, Switzerland, and Japan, the solution for cost control and price transparency is the same-- *the government sets the prices for prescription drugs, tests, treatments, hospital stays, and pretty much everything else.*


“Health is not a consumer good but a universal right, so access to health services cannot be a privilege.
POPE FRANCIS
BERNIE
U.S. SENATOR for VERMONT
SANDERS