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Decision Making In Consumer-Directed Health Plans

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Foreword

After a brief period of relatively modest growth in the 1990's, annual health insurance premiums have returned to double digit increases.[1] Past efforts to contain costs have failed, most recently managed care, largely because consumers and providers object to excessive restrictions on the use of services.[2]

Employers, who pay the lion's share of premiums for workers,[3] are reacting to escalating health care costs by seeking other ways to contain their expenditures for workers' health care. One approach is to advance health "consumerism" through the introduction of "consumer-directed health plans" (CDPs) that either supplement or supplant more traditional models of coverage. CDPs assume that the third party payer system has shielded consumers from the true cost of care, and therefore, that they have little incentive to be economical in making health care decisions. Presumably, if consumers are provided with adequate information, they will be motivated by greater personal financial responsibility to be more cost conscious. Galvin and Milstein have summarized the "considerable challenges" that face implementation of this approach: adequate and comprehensible performance data, administrative feasibility, evidence that high deductibles could pose a barrier to needed care, and concerns about equity.[4]

In anticipation of a greater market presence of CDPs, AARP commissioned this study to gain an understanding of the skills consumers would need to navigate these new models of health insurance and to recommend the types of decision supports that could address the identified needs. Recognizing the wide variety of possible iterations of CDPs, we asked the authors to identify plan features that would generally be found in most models.

The authors report that the challenges in CDPs are not new to consumers—they already face many of them if they are to make optimum use of their current coverage options. However, the authors note one important difference between prevailing models and the newer ones—there is far greater personal risk for consumers in CDPs (which is exactly the goal of CDPs).

Because greater risk and more responsibility for consumers are inherent in the model, health insurance sponsors (e.g., employers, public purchasers) who offer CDPs will have to assume concomitant responsibility. For example, purchasers (who select the options offered to their employees/beneficiaries) and regulators (who oversee the rules of the marketplace) must ensure that adequate information and appropriate tools are made

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[1] The Henry J. Kaiser Family Foundation and Health Research and Educational Trust. *Employer Health Benefits, 2002 Annual Report*, Exhibit 1.1, p 14.
[2] Ginsburg, P. "Eight Things You Should Know About Health Care Cost Trends." Alliance for Health Reform Briefing. August 2, 2002.
[3] The Henry J. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits, 2002, Annual Report*, Exhibit 6.2, p 76.
[4] R. Galvin and Milstein, A. "Large Employers' New Strategies in Health Care" in " Sounding Board". *New England Journal of Medicine*. Vol. 347, No. 12, p. 940.

available to facilitate informed consumer decision making and ensure consumers protections in the marketplace. Both public policy and private sector responses are needed to guide the development of standardized measurement, data collection, and dissemination, as well as decision support tools to assist diverse consumers to navigate an increasingly complex, often perplexing, health care system that will likely include CDPs. While there will be overlap, lead responsibility for oversight, research and development (of quality measures and consumer support tools), and standard setting are appropriate roles for government. Implementation of best practices through contracting decisions and dissemination of reliable and valid information are key activities for private purchasers. Their combined efforts will be necessary to support informed consumer decisions.

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Executive Summary

Background. With the managed care backlash and more explicit demand for greater choice, many purchasers are contemplating strategies that shift more responsibility for cost and quality to consumers through new models of health insurance sometimes known as consumer-directed or defined contribution plans. These models assume that if consumers have more choice, the right financial incentives, and appropriate information, they will be better informed and more prudent users of care. The unifying objective of these models is to shift responsibility for the cost and quality of health care from the employer to the employee. In this report, we focus on, "consumer directed plans" (CDPs).

Purpose. The purpose of this report is to examine what will be required of consumers to effectively navigate CDPs and to explore the types of decision supports that will be needed to assist them. We assess the challenges that consumers will face in making choices under CDPs and then discuss approaches to providing information and decision tools that will help them meet those challenges.

Methods. The different types of decisions that consumers will have to make in CDPs are delineated, including those that they will have to make initially upon plan selection, and those that they will make on a day-to-day basis. Drawing upon decision-making theory and research, we discuss the cognitive challenges that these different types of decisions will pose for consumers. The evidence about strategies that may help consumers overcome the identified challenges is also discussed.

Findings. Consumers face challenges both in the initial decisions they must make and in the ongoing day-to-day choices they make while seeking care. These include:

- understanding information about options;
- identifying information relevant to one's personal situation;
- knowing the factors to consider in a choice;
- integrating that information into choices, including differentially weighting factors and making trade-offs among factors; and
- understanding the implications of choice for personal financial and health risks and considering those risks when making choices.

Although consumers face most of these challenges in more traditional health coverage options, the stakes both personal and financial are, potentially, far greater in CDPs.

Three key processes are identified that will help individuals use information to make informed choices and better meet the challenges of CDPs. First, lowering the cognitive effort required to use information in choice can lead to its greater use. This can be done in a number of ways, including simply reducing the amount of information an individual must process. Second, consumers may lack an understanding of what a choice might mean to them in their daily lives and therefore fail to consider it or weight it

properly in making choices. Information that helps consumers understand the implications of their choices can improve the decision process. Finally, because consumers tend to rely on information and factors they view as more salient, information displays can be designed to highlight the meaning of information that is important but often overlooked by consumers.

In view of the absence of experience with CDPs, it will be important to lay a strong research foundation to guide and evaluate efforts as the models evolve. Observing the early experiences of enrollees, examining the validity of the underlying assumptions of the model, evaluating how more vulnerable populations fare, and assessing strategies that are designed to overcome challenges associated with implementation should be priority research targets.

Summary and Conclusions. CDPs have potential advantages for consumers. They offer more freedom of choice and loosen the explicit restrictions imposed by other insurance models. CDPs also offer the potential of lower premiums and give consumers more control over their health care. However, the evidence reviewed here suggests that there may be serious challenges for consumers who enroll in CDPs and significant barriers to achieving larger policy goals. The difficulty of the decision tasks required of consumers and the skills needed to successfully manage within these plans may be beyond the level of effort many consumers are willing to expend and may be beyond the ability of others. If this is the case, then many consumers may not make the types of informed choices that are necessary to achieve either individual or policy goals. The amount of effort, skill, and knowledge needed to make choices could discourage voluntary enrollment in these plans by those with lower decision and literacy skills--possibly leading to an important source of selection bias.

Much can be done to improve the way information is presented to consumers in CDPs. Well-designed decision-support tools, evaluable information displays, and the use of other strategies that help consumers understand and weight factors key to their choices will support more informed decision making. (Many of these strategies would benefit consumers, regardless of which plan type they select.) However, given the expense and expertise required to implement these strategies, it is not clear that they will be undertaken by plan sponsors. Moreover, even if they are, there is still some question as to whether they will be sufficient to achieve individual or policy goals for CDPs.

Research shows that consumers who are engaged in their care, and are part of decision making and help to determine the goals of their own care, have better health outcomes (Von Korff, Gruman, Schaefer, Curry, and Wagner, 1997; Lorig et al., 1999; Kaplan, Connolly, and Greenfield, 2000). Will this principle of involvement and control also apply to consumer involvement when it comes to provider and utilization choices within CDPs? Or is this level of responsibility unrealistic given the complexity of the information, the choices, and the system itself?

The success of the consumer-directed approach rests on a basic assumption: if consumers are given financial incentives, choices, and information to support their decisions, they will take charge of their health and health care and make prudent choices. Being "in charge" (or "activated") implies more than just having the right information. It means understanding and accepting a higher level of responsibility and possessing the knowledge, skills, and confidence to take this on. Will well-designed consumer information products coupled with financial incentives be sufficient to stimulate activation? There is no question that the health care system would be more appropriately used and individuals better off if they were more "activated." However, the key unanswered questions are: what will it take to activate more consumers; and what will happen to those who do not become activated?

Decision Making In Consumer-Directed Plans

Background

Over the last 35 years a variety of health care cost containment strategies have been tried, including the passage of federal programs (Medicare and Medicaid, which relieved the private sector of expenditures for eligible beneficiaries,) wage and price controls, and managed care; none of these has succeeded in containing costs on a long-term basis (Altman and Levitt, 2002). Employers, who are the primary source of health coverage for most Americans under the age of 65, continue to seek ways to stem increasing expenditures for employee health care. With the managed care backlash and more explicit consumer demand for greater choice, many purchasers are contemplating strategies that shift greater responsibility for cost and quality to the end user of care--the patient--through new models of health insurance known as consumer-directed and defined contribution models. To a greater or lesser degree, this shift is being considered in the private sector as well as in public programs such as Medicare. Although these models are not yet widespread in the marketplace,[5] they are garnering increasing attention. This is because not only might they reduce employer expenditures for health benefits, but they will use the internet to provide consumers with more information and decision support tools, facilitate greater flexibility for purchasers, and offer more opportunities for customization of benefit packages.

The terms "consumer-directed" and "defined contribution" are often used interchangeably, although they are not synonymous. Gabel, et al. categorize the former as a health plan design feature and the latter, as a contribution strategy. In *consumer-directed* plans, employees typically have more financial responsibility for the choices they make and are more actively engaged in benefit selection and network design. In *defined-contribution* plans, employers provide employees with fixed amounts for health insurance and employees shoulder any costs above the fixed amounts. In this report, we focus on consumer-directed plans (CDPs) because, for our purposes, it is more broadly applicable to the models that are likely to gain favor in the marketplace.

Central to the CDP approach is the belief that with more financial risk sharing, consumers will become an assertive force against excessive health care spending (Iglehart, 2002, Herzlinger, 2002). In general, the model assumes that if consumers have more choices, the right financial incentives, and appropriate information, they will be better informed and be more prudent users of care. It is important to note that the health care marketplace is currently very fluid, and a single label cannot capture the diversity that is already apparent among CDPs. Each example is unique, although it is possible to identify certain common features.

[5] Experts estimate that about 1.5 million Americans are currently enrolled in some type of CDP (see Gabel, Lo Sasso, and Rice, 2002).

In general, CDPs share the following common elements: (1) increased cost-sharing for consumers; (2) greater choice of cost-sharing and benefit levels; (3) the centrality of information and education; and (4) internet applications to administer the program (Murphy, 2002). The unifying objective of the model is the intent to shift responsibility for cost and quality for specific health care services from the employer to the employee (Nichols, 2002).

Purpose

The purpose of this study is to examine what will be required of consumers to effectively navigate CDPs and to explore the types of decision supports that will be needed to assist them. Drawing upon decision-making research and cognitive psychology, we assess the challenges that individuals will face in making choices under CDPs, and then discuss approaches to providing information and decision tools that will help consumers meet these challenges. Although several major policy issues such as tax policy, risk segmentation, and risk adjustment must be addressed to fully understand the implications of these plans, these issues are beyond the scope of this study.

Methods

We begin by assessing the theory upon which the CDPs are built and the adequacy of that theory for understanding human cognitive processes and decision making. An alternative theory that describes how people make choices and identify priorities is presented, and the implications of the alternative for the implementation of CDPs are discussed. We then delineate the different types of decisions that consumers will have to make in CDPs, including those that they will make initially upon plan selection, and those that they will make on a day-to-day basis. Drawing upon decision-making theory and research, we discuss the cognitive challenges that these different types of decisions will pose. The evidence for strategies that will help consumers overcome the identified challenges is also discussed.

Findings

Theoretical Bases of Consumer-directed Health Plans

CDPs are based on Utility Theory, which posits that with adequate information, consumers will make choices that maximize their interests. The theory assumes that those making choices are:

- able to identify their interests;
- completely informed about the possible courses of action and their consequences;
- sensitive to differences among alternatives; and
- able to make decisions that maximize their interests.

Utility Theory assumes that people understand what their preferences are when they review information and can use information to maximize their best interests. However, the process of deciding is more complex than is reflected by the theory. A very large body of evidence indicates that Utility Theory is of limited value in describing human decision making (Slovic, Lichtenstein, and Fischhoff, 1988). We know that, when making choices that are complex, unfamiliar, and carry important consequences, people often do not have pre-existing ideas about their preferences. Instead, they tend to construct their preferences in the process of deciding (Slovic, 1995). The problem with these "constructed preferences" is that they are highly influenced by how information is presented. The health care environment reflects exactly this situation. For example, the consumer-directed approach assumes ideal rational decision making in which consumers maximize their interests. As discussed below, however, this ideal may be difficult to achieve.

The new paradigm of constructed preferences posits that consumers will be highly influenced by how information is presented and framed (Slovic, 1995). The influence of presentation format on the use of information has been demonstrated in a variety of decision-making contexts. For example, simply changing how breakfast cereals are ranked in a list showing unit pricing appears to change purchasing behavior among grocery store shoppers (Russo, Kreiser, and Miyashita, 1975). Of course, consumers are much more knowledgeable about breakfast cereals than they are about health care providers, which suggests that health care choices may be even more influenced by how information is presented. Controlled studies examining consumer choice and the use of performance information strongly support this perspective (Hibbard, et al, 2000a; Hibbard, et al., 2002b). Consumers who received information framed as a gain as (compared to a loss) made different choices (Hibbard, et al., 2000b). Information displays made more evaluable also affect whether that information is actually used in making a choice. The evaluability principle, derived from cognitive psychology, asserts that the weight given to an attribute in a choice is proportional to the ease or precision with which the value of that attribute creates an affective (good/bad) feeling (Hsee, 1995, 1996, 1998). This principle was supported in controlled laboratory experiments with consumers provided comparative performance data formatted to be more or less evaluable. Such studies showed that evaluable formats, such as ranking items from best to worst, influenced the weighting of the performance information and the decision outcome (Hibbard, et al., 2002b).

How information is presented may be as influential as its content. This point is critical as we consider the choices that consumers in CDPs are asked to make and the kind of information that they are given to support these choices. A lack of attention to information presentation approaches could easily undermine consumers' ability to maximize self-interest in choice.

Plan Models

As noted earlier, it is difficult to provide precise definitions of CDPs. In this report, we rely on a three-model typology suggested by Gabel, Lo Sasso, and Rice, (2002): (1) health reimbursement arrangements (HRAs); (2) employee-designed network and benefits; and (3) customized packages. Models 1 and 2 require fixed contributions to work; Model 3 does not necessarily require this contribution strategy. We briefly describe the three models and then analyze the implications for consumer choice inherent in each one.

(1) *Health reimbursement arrangements (HRA*). Personal spending accounts are established for each employee and they may draw upon the accounts for their health care needs. When their accounts are depleted, the employees pay out-of-pocket until they reach annual deductible amounts, at which time traditional major medical policies (or other insurance arrangements) go into effect. Examples of this model are Definity Health, Lumenos, and Destiny Health.

(2) *Employee-designed Benefits and Networks***.** Employees establish their own networks and design their benefit packages by selecting specific doctors and benefits. They bear the financial risk of their choices. Thus if the doctors selected charge higher prices, employees will incur greater expenses. Likewise, if employees require benefits not selected, they will have to pay out-of-pocket when they need such services. Vivius is an example of this model. It requires individuals to construct networks consisting of 19 physicians representing the range of specialties patients are likely to require (Newcomer, 2002).

(3) *Customized Packages***.** Employees select from among various networks and benefit packages that have been predetermined by their employers. Employees may choose from broad or narrower networks and richer or less comprehensive benefits. Most of the major managed care insurers (e.g., Aetna, Humana, CIGNA) have begun to offer this model, sometimes combined with HRAs and tiered networks (e.g., PPOs or HMOs) that vary by price.

Key Challenges for Consumers under Consumer-directed Plans.

Just as with the more traditional health coverage options that are currently available in the marketplace, CDPs will require considerable effort and responsibility from consumers. The major difference is that, in CDPs, *the financial and personal health stakes are potentially higher, because consumers/patients usually bear more risk and responsibility for their decisions under the newer models of coverage.*

As a first step, consumers will need to understand how the new approach works and what their roles are in making it work. This requirement in itself is challenging, as comprehending the current, more familiar health plan options already presents problems for many consumers (Garnick, et al., 1993; Isaacs, 1996). Recent focus groups in California confirmed that consumers had serious difficulties in understanding the CDP approach (California Health Decisions, 2002). Even after having been provided with a detailed explanation, most participants were still confused about how these new plans worked. Many perceived that consumer-directed plans are the wave of the future, and they wanted to understand them better. Focus group participants worried that because the health system is so complex, they would not have the time or skills to research their

options properly. Although they welcomed more choice and more control over their health insurance, they were concerned that they did not know enough to make good decisions. While the stated goal of these plans is to activate consumers to make more informed choices, the first major hurdle appears to be educating them about how their plans work.

Another major hurdle concerns the assumption that consumers will use information to inform their choices. This implies that they will be able to process a large volume of information and discern which portion is relevant to their situations. However, as noted, the model of constructed preferences indicates that the way information is presented will affect how it is used. In addition, research shows that decision makers will often retrieve both relevant and non-relevant information in their search and will then use both types to make their choice (Bastardi and Shafir, 2000).

Consumers face challenges both in the initial decisions they must make and in the ongoing day-to-day choices that emerge while seeking care. In the next section we look at the types of decisions that consumers would have to make under the CDPs and the cognitive challenges these decisions might pose for them.

Initial Enrollment Choices.

Initial enrollment choices consist of several tasks and require different skills from consumers. The tasks and necessary skills will vary, depending on the CDP selected. For example, in a CDP that follows the HRA model (Model 1), the key decision tasks for the new enrollee could involve making trade-offs concerning deductibles, premiums, and personal spending account levels. Does the individual want more discretionary dollars for spending on a broad range of health care and health products, a lower monthly premium cost, or a lower level of financial risk? If a consumer does not anticipate needing much care, then having a higher deductible and a lower monthly premium might be a sensible choice.

Of course, these trade-offs implicitly require judgments about the likelihood and extent of care needed in the coming year. Such predictions are difficult for people to make, and research suggests that individuals consistently under-estimate personal risk. Under-estimation of risk is particularly likely when hazards are perceived as low in probability; when individuals have had little personal experience with the risk; or when the risk is judged to be controllable by personal action. This “optimism bias” in risk judgments is robust and widespread (Slovic, 2001; Weinstein, 1989). Thus, there is likely to be a strong tendency for those who are in good health to assume the best and make choices that may not turn out to support their best financial or health interests. Those who use health care services often may be better able to calibrate their needs as a result of their experiences. Life offers unexpected events to everyone, however, and the individual consumer will bear the brunt of any mistakes that are made.

The challenge: how to help consumers understand their risks and make choices that protect against events that are not currently salient.

Under Models 2 (Employee-Designed Benefits and Networks) and 3 (Customized Packages) the initial decisions involve making provider or network choices along with benefit designs. Each of these includes numerous options, and each option has a number of factors to consider, including cost and multiple quality indicators. Additional factors, such as location of physician offices or desire to maintain on-going relationships with providers, may also enter into the mix. Although some have likened these decisions to a trip to the grocery store, consumers have a lifetime of experience with grocery stores, and the choice of a laundry detergent does not have nearly the potential impact as the choice of a surgeon.

A critical element in decision making is the ability to interpret and integrate multiple pieces of information into a choice (Slovic, 1982). The conclusions from numerous empirical studies suggest that the integration of different types of information and values into a decision is a very difficult cognitive process (Tversky, Sattath, and Slovic, 1988). Evidence shows that people can process and use only a limited number of variables (Slovic, 1982). Further, having to differentially weight several factors and make trade-offs among them also adds to the cognitive complexity of the task.

For example, the need to differentially weight different factors would occur when one provider achieves different scores on multiple indicators: two of the indicators show excellent performance, two show average performance, and one shows poor performance. To use this information in choice, the enrollee would need to decide how important each performance factor is for his or her personal situation. In controlled laboratory studies, it was observed that people were often unable to differentially weight performance measures in choice. Even when they thought they were doing so, they often were not. Findings from these studies showed that information displays (unconsciously) affected consumers' differential weighting in choices, often overriding their actual intentions in weighting (Hibbard et al., 2002b).

Under Models 2 and 3, enrollees will have to make a trade-off between premium cost and provider performance. When faced with these kinds of trade-offs, individuals appear to give more weight to variables that are precise and concrete and less weight to factors that are inherently harder to evaluate (Hsee, 1996; Mellers, Richards, and Birnbaum, 1992). This suggests that when consumers have to balance premium costs against quality factors, costs (which are precise and understandable) may outweigh quality factors (which tend to be vague and less well understood) (Hibbard, 1998; Hibbard, Slovic, and Jewett, 1997).

When faced with the complexity of trade-offs and differential weighting or an overwhelming amount of information to process, consumers typically cope by taking short cuts in decisions. Instead of considering all the factors and deciding their relative

importance, individuals simply decide on the basis of one or two factors and ignore the rest. These short cuts make the decision process easier but may undermine the decision maker's self-interest.

The cognitive complexity of these initial enrollment choices could be reduced by well-designed decision support tools. Without such tools, enrollees will likely find the process burdensome and may make suboptimal choices.

The challenge: how to help people make trade-offs and decisions that will achieve their goals.

Day-to-Day Decisions for Enrollees

The choices that enrollees make on a day-to-day basis may have financial and health consequences. These include decisions about:

- when to seek care;
- selecting providers;
- spending the personal spending account versus saving funds for a future serious illness; and
- seeking care once the account is exhausted.

Decisions About When to Seek Care. We know that when people have to pay larger shares of the cost of care, they reduce their utilization (Lohr, et al., 1986). Because they have financial incentives to use fewer services in a CDP, it is assumed that consumers will make more conservative decisions about when they need to seek care and when they can address the problem on their own without a physician encounter. Twenty-four hour nurse advice lines are available to enrollees to help them determine if they need to seek care, or to instruct them on how to self-treat their problems. There is some anecdotal evidence that those enrolled in CDPs use the nurse-advice lines at almost twice the rate of those enrolled in more conventional plans (Personal communication, Chris Delaney, Definity Health, 2002).

The evidence about the efficacy of nurse advice lines appears to support the view that they can reduce unnecessary utilization. In a randomized clinical trial in the United Kingdom, the authors reported that nurse advice lines reduced demand for emergency care and reduced the overall workload of general practitioners by 50 percent while allowing for faster access to health information and advice (Lattimer, et al., 1998; Lattimer, et al., 2000). Whether this will translate into reduced care in the United States is not clear and may depend on the threshold that advice protocols have for recommending contact with a doctor (Shekelle and Roland, 1999). Further, it is not known whether also having a financial incentive along with the nurse advice line makes a difference in consumers' use of services.

In an evaluation of a community intervention designed to increase self-care and reduce health care utilization, the characteristics of those using nurse advice lines were examined. Individuals most likely to use the advice lines were younger adults with children at home. Those who had less access to care, such as those with no regular

sources of care and those with no health insurance, were also more likely to use nurse advice lines (Hibbard, et al., 1999). This suggests that as exhaustion of the personal spending accounts approaches (and individuals lose third-party coverage for some forthcoming expenses), the nurse advice line may be a particularly important resource to help consumers discriminate about when they need care and when they do not.

The challenge: to help consumers make good choices on a day-to-day basis about when it is necessary to seek care and to assist them in making good choices about the kinds of care that they need.

Selecting Providers. In CDPs, enrollees may have a large number of individual or networks of providers from which to choose. They may be given quality ratings and descriptive information to help them select doctors and institutional providers. These choices carry financial implications for enrollees. Linking performance information with these provider/network choices is key to assisting individuals to maximize their financial and health care interests. However, the experience to date with providing consumers with comparative performance information to help them make selections has been disappointing. Although consumers show interest in having such information, they have not widely used it to inform their choices (Marshall, et al, 2000; Hibbard, et al., 2002a; Knutson, et al., 1998; Chernew and Scanlon, 1998; Scanlon, Chernew, and McLaughlin, 1999). One explanation for this, discussed in the previous section, is the complexity of the task of interpreting information on health care quality and the cognitive burden that it imposes on decision makers. Further, it is not clear that consumers have been given material that they perceive as understandable, usable, and timely. It will not be until information on quality is made much more widely available that we will be able to say with any confidence whether consumers will or will not use it.

Research from decision scientists shows that when the number of available options is larger, different choices emerge that may not be intuitively obvious. For example, in choices involving tradeoffs among three versus two options, subjects avoided the extreme option and chose the option with the medium score on the attributes (Shafir, Simonson, and Tversky, 1993). With larger numbers of options, consumers may also be more likely to defer decisions or choose the status quo (Redelmeier and Shafir, 1995; Tversky and Shafir, 1992). These outcomes are not likely to be the ones that the consumer-directed approach is seeking to achieve.

In addition to the limitations of human information processing, there is the added difficulty of the adequacy, availability, and accuracy of comparative information for consumer use. For instance, performance information at the provider level is not readily available, other relevant information on quality may be incomplete or non-existent in many markets, and the range of quality indicators, when they are available, may not be specific enough to inform individual choices. To illustrate this point, Health Grades, a web-based company that offers comparative data on hospitals and physicians, only provides hospital performance information on limited clinical areas and "profiles" physicians without providing actual information on the quality of care they provide.

If provider and/or network cost information is not linked with performance information, consumers may view cost as a proxy for quality and choose higher cost providers, thereby undermining a key goal of CDPs.

The Challenge: to provide consumers with complete and relevant information that helps them integrate all the important factors, including quality and cost information, into the selection of providers.

Decisions About Spending the Personal Spending Account Versus Saving Funds in the Event of a Possible Future Serious Illness. Deciding whether to use the personal spending account for elective health care products and services or conserving the funds to use in case of a serious health problem could be a central day-to-day decision task for enrollees in CDPs. The enrollee must balance the needs and wants of today with possible future needs. This is difficult for three reasons. First, as mentioned earlier, a person may have difficulty accurately assessing the likelihood of future events and their probable impact or severity.

Second, we know from decision research that an individual may find it difficult to accurately anticipate how he/she will feel and what the priorities should be under changed circumstances (March, 1978; Christensen-Szalanski, 1984). A person in good health cannot always foresee what his or her needs or priorities will be during a serious illness. What an individual may anticipate wanting can be quite different from what he/she actually wants when facing changed circumstances (Brickman, Coates, and Janoff-Bulman, 1978). For example, a well person may not anticipate how he or she will feel about coping with a substantial financial burden (such as a depleted personal spending account) while simultaneously coping with a serious illness.

Finally, what a person wants in the present tends to have a larger impact on choices than future needs or desires (Loewenstein, 1996). If we look at the rise in credit card debt or how well people save for retirement, we can see that a large portion of the population has difficulty balancing current wants with future needs. In the past two decades, the personal saving rate in the United States has dropped dramatically; from 10.6 percent of disposable personal income in 1984 to –1.0 percent in January 2001 (Lusardi, Skinner, and Venti, 2001). Clearly, people know they need to save for their retirement and yet many fail to do so.

The challenge: to help people make choices that will allow them to better forecast and then balance current wants with possible future needs, and to assist them in understanding the meaning or potential impact of the risks they are assuming.

Decisions About Seeking Care Once the Personal Spending Account Is Exhausted. Once the personal spending account is exhausted, an enrollee will need to pay for the full cost of care until the selected deductible level is reached. This can be a substantial amount of money, and will, of course, be more burdensome for a person with fewer resources and greater health needs. A key question is how will an enrollee behave under these circumstances? This is particularly important for the individual who has a chronic disease and requires on-going medical care. Will care be used more judiciously,

or will enrollees forego needed care? We do know that when a person is under pressure because of illness, financial concerns, or other stressors, his/her decision making may change to use more mental shortcuts and reliance on emotional factors, increasing the possibility of impulsive and suboptimal choices (Cassell, Leon, and Kaufman, 2001).

There is evidence that increased exposure to the cost of care reduces health care utilization. The RAND Health Insurance Experiment, however, found that people are unable to discriminate appropriately when they cut back on care. Thus, they are as likely to forego needed, effective services as they are to skip ineffective services. In addition, cost-sharing appears to have its strongest effect on the utilization decisions of lower income families (Lohr, et al., 1986). A recent study showed that increased cost-sharing for prescription drugs in elderly persons and welfare recipients was followed by reductions in the use of essential drugs and a higher rate of serious adverse events and emergency room visits associated with these reductions (Tamblyn et al., 2001). Therefore, lower-income families would likely reduce care to a greater degree when their personal savings accounts are exhausted, and this reduction could result in serious health effects and lead to higher long term costs.

There is reason to be concerned that those with both less skill and fewer resources may be further disadvantaged in CDPs. Focus group research with consumers in California on the topic of CDPs found that those groups with lower income and education had the most difficulty simply understanding how the plans worked (California Health Decisions, 2002). Research on consumer use of comparative performance information in choice showed that as many as 57 percent of Medicare beneficiaries had difficulty accurately interpreting simple data displays (Hibbard, et al., 2001). As this is the easiest step in using information for choice, many more would have difficulty incorporating this information into their choices. Overall, low literacy is a pervasive and under-recognized problem in health care. Approximately 21 percent of U.S. adults are functionally illiterate, and another 27 percent have marginal literacy skills (Davis, et al., 1998). Functional illiteracy is estimated to be higher among racial minorities, older persons, and those with chronic diseases. Such consumers may have difficulty reading and understanding the information that they will need to make informed choices within CDPs. Because informed choice is central to the approach, those with fewer decision-making skills will likely be further disadvantaged under CDPs, and this raises the specter of exacerbating existing health disparities.

Moreover, since consumers with lower skill in using information to inform choice are more likely to want to avoid making complex choices or prefer to delegate those choices to others (Hibbard, et al., 2001), they may not be attracted to these plans. This raises a different set of concerns related to the possibility of selection bias that is based on an individual's ability to choose -- a source of selection bias that is not usually considered. If only the more skilled and advantaged segments of the population are attracted to consumer-directed plans, this could be an additional source of selection bias (along with the often cited concern of bias selection based on health status).

A summary of key challenges for consumers under consumer-directed plans includes**:**

- understanding information about options;
- identifying information relevant to one's personal situation;
- knowing the factors to consider in a choice;
- integrating that information into choices, including differentially; weighting factors and making trade-offs among factors; and
- understanding risks and considering those risks when making choices.

Processes to Help Consumers Make the Best Use of Information

Thus far we have elaborated on the types of decisions consumers are required to make in CDPs and the challenges and potential pitfalls they will face in making those choices. We now examine potential strategies to help overcome those challenges. Because the way information is presented can be so influential in the choices that are made, we focus our discussion on presentation strategies that address the identified challenges.

In this section we discuss three processes that will help individuals use information to inform choices. First, lowering the cognitive effort required to use information in choice can lead to its greater use. This can be done in a number of ways, including simply reducing the amount of information individuals must process. Second, consumers may lack the understanding of what a choice might mean to them in their daily lives. For example, individuals choosing primary care physicians may not have had experience in dealing with physicians who lack good communication skills, making it difficult to comprehend what this experience might be like. As a result, these enrollees will not weight differences among physicians on this attribute (skill in communicating) when choosing. By helping people to have a better idea of what the actual experience of a choice (or the consequences of a choice) might be like, key attributes are more likely to be considered in the choice process. Finally, because consumers tend to rely on information and factors they view as more salient, information displays can be designed to highlight the meaning and significance of information that is important but often overlooked by consumers (Hibbard and Peters, 2003).

Each of these three processes (lowering cognitive effort, helping people to understand the experience of a choice, and highlighting the meaning and significance of information) can enhance consumer use of information through specific presentation strategies.

Lowering the cognitive effort required. One of the difficult issues for consumers is the vast quantity of information processing needed to make informed choices. The amount of information alone can be overwhelming to those making decisions. Faced with too much information, and often conflicting information (such as in the risk/benefit tradeoffs inherent in many choices among treatment options), some decision makers may determine that the effort required is not worth it. Others may recognize that they are simply not capable of processing the information (Hibbard, et al., 2001).

Cognitive burden can be reduced in a number of ways, including the use of computer-aided decision tools. Decision tools can ease the burden in decisions by structuring the decision process and by highlighting the important factors for consideration. The decision task can be broken down into smaller decision steps, and the computer can use the decision maker's own values and preferences to differentially weight variables in making choices. Thus, decision tools can carry out some of the burdensome cognitive tasks for the decision maker. However, the development of well-designed decision tools for all the different types of decisions necessary under CDPs would be costly and require specialized expertise.

Using an "evaluable" visual display of information designed to lower cognitive effort can also help consumers integrate information into choices. Evaluable data displays help the viewer by providing cues to transform the information onto an evaluative good/bad scale (Hsee, 1996; Hsee, 1998). Instead of having to think hard about how to evaluate information regarding an option, an evaluable display reduces the effort required by providing these evaluations in a simpler form. For example, Figure 1 below compares costs associated with different Medicare plans. By adding the "Best Value" label, the information producer has summarized several pieces of information by making it more apparent which are the better options. Thus the information is more evaluable.

Figure 1. Example of an Evaluable Display

Insurance Plans		***Co-Pays***	***Premiums***	***Co-Pay for Brand Drugs***
Health Advantage	***Best Value***	$10	$35	$25
Secure Horizons		$15	$45	$30
Advantage Plus		$20	$35	No coverage
Health-Net	***Best Value***	$15	$40	$25

The concept of evaluability is simple but profound. Information varies in the degree to which it conveys evaluative meaning. Particularly in unfamiliar domains, a consumer may not know what a measure means. Research on evaluability demonstrates that even if we understand the numbers used, at some fundamental level, we may not have an emotional or affective understanding of it. (For example, is this information telling me that this option is good or bad?) And when information lacks emotional

meaning, it is not evaluable and is thus not weighted properly in decision making (Slovic, et al., 2002). A consumer may be able to determine meaning through considerable effort in comparing and contrasting available information. However, it appears that the consumer often does not go to this extra effort and may rely instead on information that is, a priori, more evaluable. Evaluable data displays make all of the information about a choice available in a simple good/bad form (so that the consumer can compare apples to apples). For example, a consumer choosing among price-tiered hospitals would be able to use both quality and cost information more easily if the hospitals were ranked by performance within each cost tier. The enrollee could quickly see the best options within each cost tier and would more likely use both cost and quality information in the choice than if cost and quality were presented separately. Making data evaluable simplifies the task for the decision maker and influences the interpretation and comprehension of the information. By providing information in an explicitly evaluable form, it can be used more easily to assess overall how good or how bad any one option is. Figures 2 through 5 below provide additional examples.

Figure 2. Unordered, less evaluable

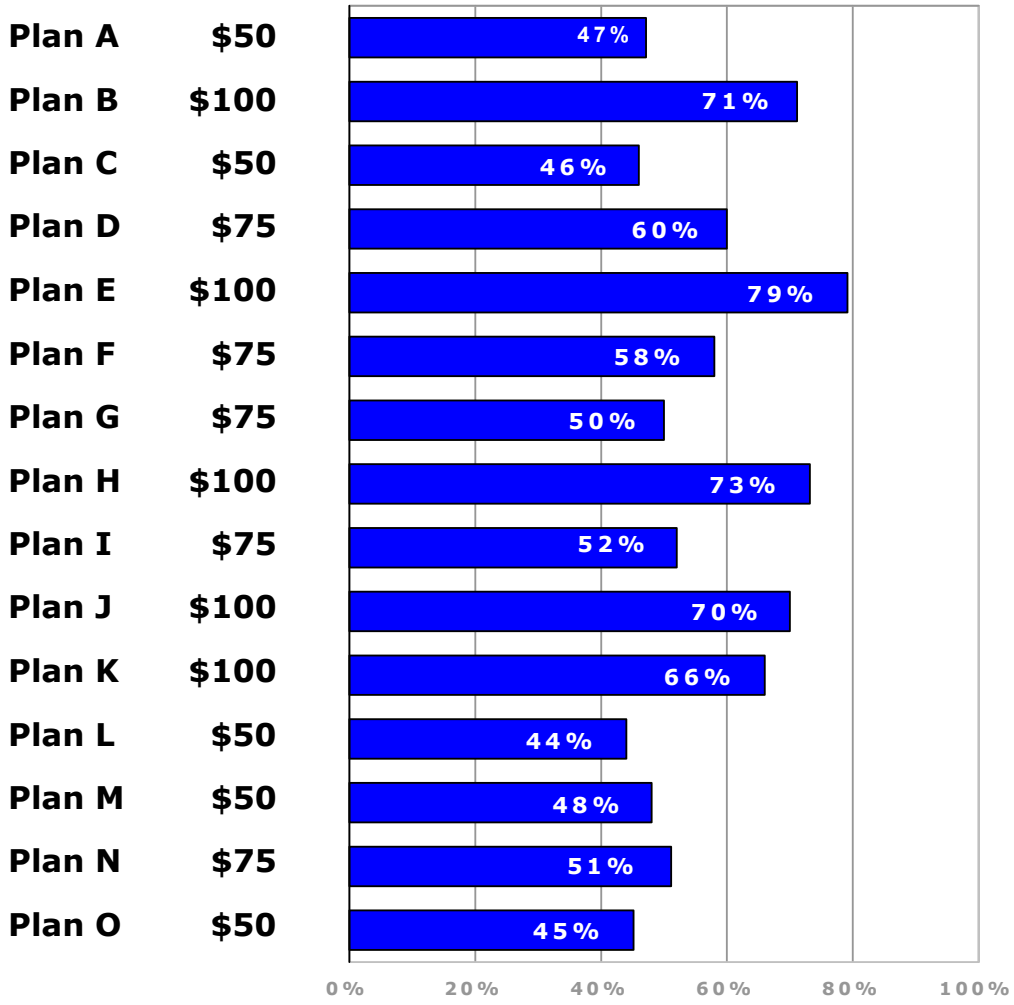


Figure 3. Ordered (more evaluable)

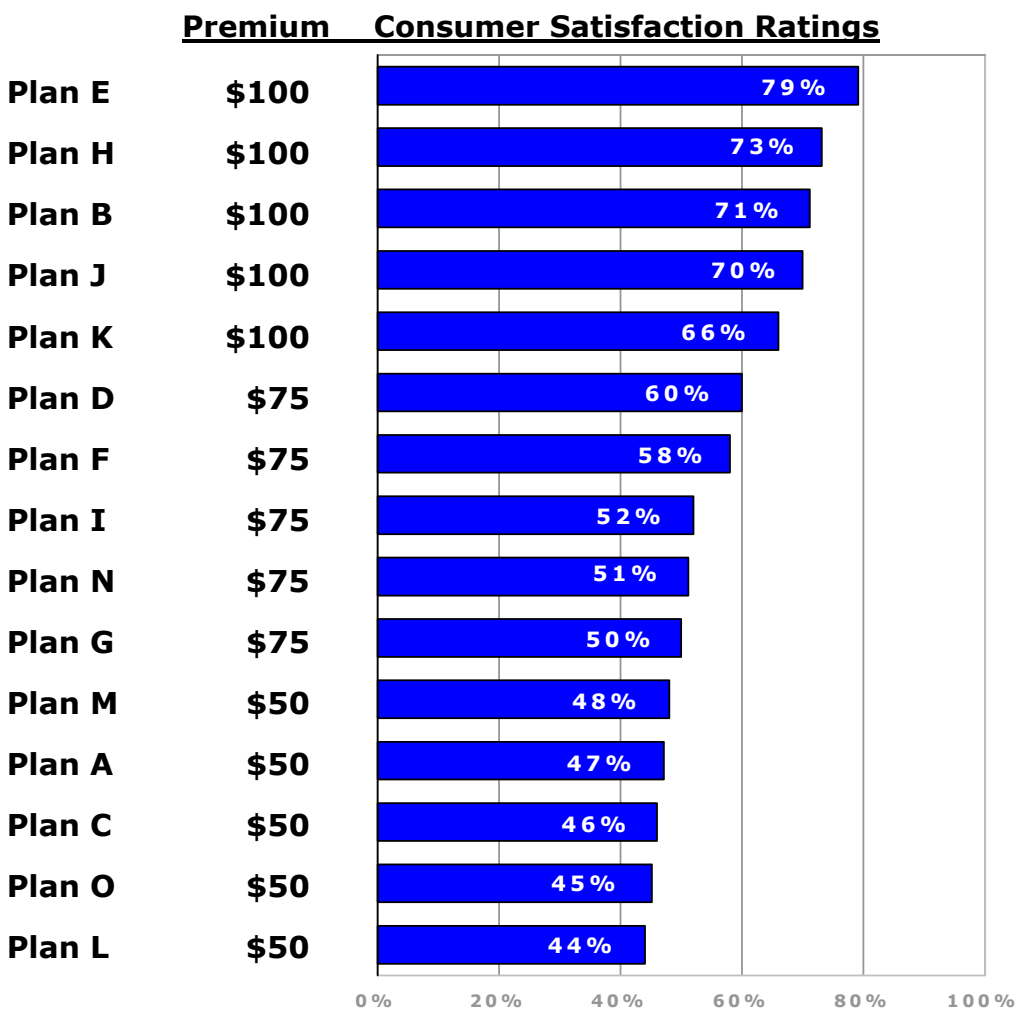


Figure 4: Bar Charts Only (less evaluable)

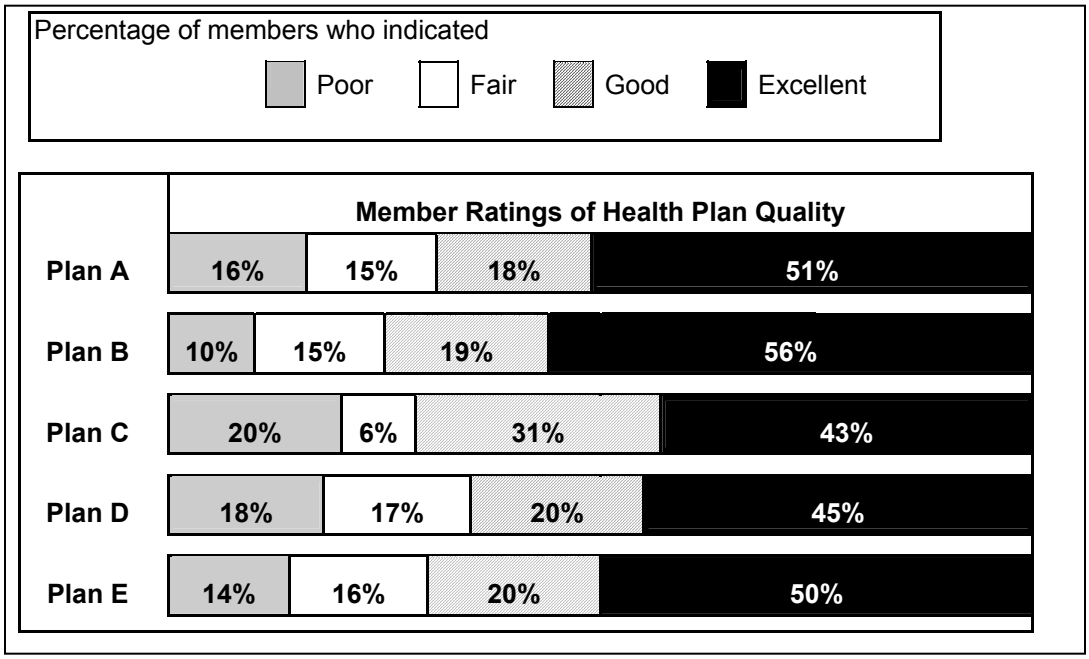
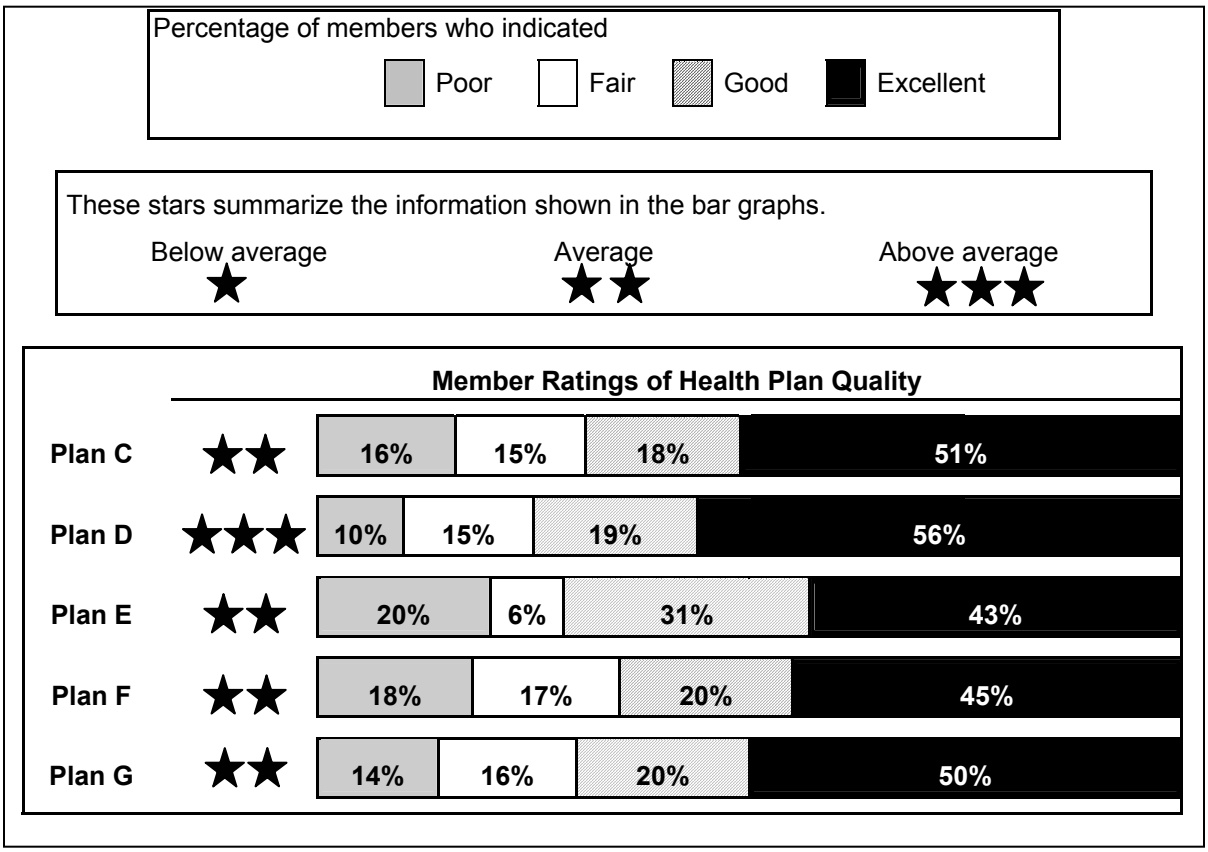


Figure 5: Bar Charts with Stars (more evaluable)



Recent controlled laboratory experiments with consumers indicate that evaluable displays of comparative data increase the degree to which information such as quality of care is actually weighted and used in choices among health plans (Hibbard, et al., 2002b).

Evaluability strategies will help in a variety of ways but are most critical for assisting consumers to process and select relevant information, and weight multiple factors in choice.

Helping People Gain a Better Idea of What the Actual Experience of a Choice Might Be Like. In choices that are not made frequently, decision makers are not able to learn from experience and develop an understanding of what differences among options a particular attribute would actually mean to their lives. For example, what would it be like to choose a treatment that required regular monitoring and on-going, time-consuming home treatment versus surgery that carried some serious risks? As has been shown in previous research on judgment and decision making, we are not always able to predict how we would feel about experiences even when they are common ones (Kahneman and Snell, 1992). When choosing among treatment options, decision makers who have never experienced the consequences of a particular choice may not be able to accurately predict its impact on their lives. Several methods of information presentation can enhance this understanding of experience by providing cues that have been salient to consumers who previously experienced the choice. As a result, good quality decision processes in which consumers comprehend information and bring it to bear on choice using their own values as a guide may be more likely to emerge.

Narratives, or stories about others experiences, provide a promising approach to help fulfill the requirements of good quality decision processes. In one recent experiment, participants were exposed to information about a topic and asked to make judgments. Half of the participants were exposed to the information in a narrative form while the other half were provided the same information in a more standard non-narrative form. The results indicated that narrative compared to non-narrative participants were more sensitized to the attributes in the situation and were better able to consider them in their judgments (Satterfield, Slovic, and Gregory, 2000). Participant responses in the narrative group indicate that they understood and integrated the information in their choices whereas those in the non-narrative group did not systematically use the information that had been provided. Thus, the information significantly influenced respondents' choices only in the narrative condition. Similarly, Sanfey and Hastie (1998) found that respondents who were given narrative information made more accurate judgments than respondents given the same information in bar graphs or data tables.

Narratives may be beneficial for presenting information, including complex technical information, for several reasons. First, narratives may help render even unfamiliar information evaluable, salient, and easily imaginable through the use of concrete descriptors and images. Second, a growing number of scholars are finding that information presented in narrative form improves memory retention (Price and Czilli, 1996). Finally, reading a narrative may make the task more engaging and, by so doing,

motivate its use in decisions. Oatley (1994) has suggested that narratives possess a variety of devices that allow readers to project the elements of the story to their own situations. In the context of selecting a provider, for example, readers may see the problem from the narrator's point of view, take it on as their own, and understand better what the experience of a choice would be like, providing motivation for considering additional factors.

In preliminary findings of laboratory experiments on Medicare health plan choices, older consumers receiving narratives along with evaluable data presentation approaches made quality-maximizing choices more often than those viewing data with no narrative and less evaluable data displays (Hibbard, et al., 2002a). (See Appendix for an example of a narrative used in the Medicare laboratory experiments.)

Vivid presentations of information are similar to narrative approaches. Presentations made vivid through pictures or language can provide greater emotional interest. For example, a picture showing a smoker breathing through a hole in her throat makes vivid the outcomes of smoking. Vivid presentations appear to have a greater impact on judgments than more pallid or bland presentations of the same information content. Sherer and Rogers (1984) demonstrated that vivid and emotionally interesting information was highly effective in changing health-related behavioral intentions.

Narratives could be used to help consumers make many decisions they must make in CDPs. Stories from other patients or enrollees could be used to help consumers understand what might be important to consider in a making choice, or what the consequences of making the choice might be. Both the use of vividness and narratives can help to make risks, such as the risk of a future health event, more real and increase the chances that individuals will consider these future risks as they make day-to-day choices on how to spend their personal spending accounts.

Narratives and the use of vivid presentations could be important in a number of decisions, including helping consumers to understand the factors that should be considered in a choice; to overcome the optimism bias; and to more carefully weigh current wants against future needs.

Highlighting the meaning of the information. Narratives, vivid presentations, and evaluable presentations all can make the meaning of information more readily accessible, which in turn will cause the information to have a greater influence on choices and judgments. For example, a narrative on the financial consequences for a family with a child who had an unexpected serious illness can help another consumer better understand the risks of depleting a personal spending account. At the same time, it may also highlight or emphasize the consequences and make the meaning (the emotional impact of what it might feel like) more available in day-to-day choices.

Another way to highlight the meaning of information is through framing. Framing may not necessarily make information more useable, but it does provide the decision maker with alternative ways to think about a decision. Framing tends to

highlight or emphasize either the potential loss or the potential gain involved in a choice. Several decades of research have demonstrated conclusively that the way a decision is framed strongly influences people's preferences, in some cases resulting in complete reversals of preference.

Building upon this earlier research, Hibbard, et al. examined framing effects on the choice of a health plan (2000b). In their experiment, one group received comparative CAHPS in the usual way as a potential gain ("how to get the best quality"). Another group received the same data, but the decision was framed as a loss or risk ("protect yourself from problems in health plans"). Framing the health plan decision as a possible loss significantly increased how well the comparative information was understood, how much it was valued, and how much weight it received in making decisions.

Framing highlights the meaning of particular information and draws the decision maker's attention to a potential outcome. Research indicates that highlighting potential loss will be more effective when framing decisions about seeking screening, treatment choice, and/or health plan selections. A gain frame will be more effective with choices around prevention (Edwards, et al., 2001; Rothman, Martino, et al., 1999).

Highlighting strategies to help consumers identify relevant and often overlooked information and use that information in decision making will improve choices and help them in their larger goals of obtaining high quality care at the most reasonable, feasible cost.

The evidence suggests that comprehension, motivation, and the actual use of the information are increased when (1) cognitive effort is reduced; (2) the decision maker is moved closer to the actual experience; and (3) the meaning of information is highlighted for the decision maker. The use of these three processes as design principles in the creation of consumer information products likely will enhance the successful use of information to inform choice. However, designing information products that will actually support informed choice will require a major effort. For example, creating evaluable reports means the report designer must summarize information and help interpret it for the viewer. This is a responsibility that few report sponsors have been willing to undertake. Yet, the research shows that if consumers are to use the kinds of complex and unfamiliar information that they will need to make informed choices, report sponsors may have to assume greater responsibility for producing and disseminating appropriate materials.

Providing information that is usable for those with fewer literacy skills will be even more challenging. Forty million Americans are estimated to have low literacy skills (National Adult Literacy Survey, 1992). In laboratory studies with Medicare beneficiaries, it was found that using narratives and evaluable data displays helped those beneficiaries with moderate levels of skill. Those in the lowest quartile of skill level were helped neither by evaluable data displays nor the provision of narratives (Hibbard, et al., 2002a). Helping consumers who have lower literacy skills may require providing

information intermediaries to assist them one-on-one, and this will undoubtedly be expensive -- both in terms of actual expenditures and the availability of trained personnel. All of this underscores the problem of applying consumer-directed models to the broad population, and raises the question of the feasibility of a policy approach that relies so heavily on informed consumers to constrain costs while maintaining quality.

Discussion

In view of the absence of experience with CDPs (Gabel, et al. 2002), it will be important to lay a strong research foundation to guide and evaluate efforts as CDPs evolve. Regarding consumer experiences with these plans, research priorities should begin with more qualitative and observational studies and then move to controlled laboratory studies and field experiments. Observing the early experiences of enrollees, examining the validity of the underlying assumptions of CDPs, evaluating how more vulnerable populations fare, and assessing strategies that are designed to overcome the challenges associated with implementation should be priority research targets.

Assessing Early Experiences

Observational research that simply tracks early experiences with CDPs is needed to answer a number of questions.

- How many consumers are offered only a CDP option?
- How many are offered CDPs as an option along with other types of plans?
- When consumers have a choice, who is (and who is not) opting into CDPs?
- What are the socio-demographic and health status characteristics of those opting into the CDPs, and how do they compare to the characteristics of those choosing other options?

It will be critical to assess consumer comprehension.

- How well do consumers understand the mechanics of these models and how they differ from other plan choices?
- Do enrollees recognize the added responsibility they are assuming in terms of making choices and the financial risks associated with CDPs?
- Do consumers understand the materials that are provided for making choices once they are enrolled? Do they find the information adequate for their needs?
- Are there components of the model that consumers have a hard time understanding?
- Are there common misconceptions and misunderstandings about CDPs?
- How well do consumers at different levels of literacy understand the choices offered and the materials provided?

It will be important to document early experiences with these plans.

- How satisfied are enrollees?
- How do their experiences compare with enrollees in more conventional types of plans?
- Are they confident that they have made the right decisions for their own circumstances?

Examining Underlying Assumptions

Research needs to focus on whether the assumptions about how consumers are going to behave in consumer-directed plans are actually borne out. Assumptions about consumer use of information, their ability to maximize their interests in their choices, and their lower use of services should be closely examined. A full assessment of the adequacy of information and decision supports should be carried out, including the degree of match between the decisions consumers make and the types of decision supports that are provided. In addition, the assumption that the provision of financial incentives coupled with information and decision support will stimulate consumers to become more activated and informed also needs close examination.

- How well are consumers able to use the information provided to them for informing their choices?
- Do enrollees use the informational materials and decision supports to make choices that reflect their stated goals? (For example, if a consumer wants to maximize quality within a cost stratum, is she or he able to make choices that achieve this goal?)
- Do utilization patterns suggest that enrollees are making appropriate decisions about when to seek care?
- Do the consumer-directed models encourage consumers to become more cost conscious in their choices? Do they use fewer resources?
- Do they do this without compromising their health?
- Do enrollees choose higher performing providers?
- Do utilization rates and expenditures decline while health and functioning are maintained?

It will be important to assess how enrollees use their personal spending accounts.

- How often do enrollees exhaust these accounts?
- What happens to utilization and to the quality of decisions once the accounts are exhausted?
- Given a consumer's health status, health risks and utilization history, is he or she making "good" decisions that protect his financial and health interests?
- Does the ability to do this differ by a consumer's literacy or educational levels?

- Do enrollees gain knowledge, skills, confidence, and motivation for taking a more active role in managing their health and health care over time? (This is a critical assumption underlying the CDP approach, and there is little experience or evidence to either support or refute it.)

In investigating these questions, it would be productive to assess enrollee experiences over time and to compare enrollees in CDPs with enrollees in conventional plans. The questions posed above could be pursued by looking at CDP enrollees over time, and/or comparing their experiences, skills, knowledge, utilization, and costs with enrollees in other plan types.

Examining How Vulnerable Populations Fare

An assessment of how consumers with differing levels of health, functioning, and literacy do under CDPs is another key area for investigation. How important are cultural and language factors in determining how consumers fare under CDPs? The research questions delineated above could include a specific focus on vulnerable populations. Tracking how these groups do over time will be crucial. A special focus on people with chronic diseases and the degree to which they are able to maximize their health care and financial interests will be particularly critical to assessing the efficacy of the CDP approach.

Evaluating Interventions Designed to Overcome Challenges

As we gain more experience with the CDPs and as the areas that present difficulties for consumers are identified, interventions will be designed to overcome them. Evaluations will be needed to assess the efficacy of these interventions. How much can carefully designed consumer information products help enrollees improve the use of information in choice? How much will the products help activate consumers to take charge of their health and health care?

Summary and Conclusions

Many employers are actively considering strategies that would shift a significant share of the responsibility for both the cost and quality of care to employees. Consumer-directed health plans are an example of this shift. At this point, the degree to which these plans will meet the needs of consumers is not known.

The CDP approach has potential advantages for consumers. It offers more freedom of choice and loosens the explicit restrictions imposed by tighter models of managed care. It offers the potential of lower premiums and gives consumers more control over their health care. However, the evidence reviewed here suggests that there are serious challenges for consumers who enroll in consumer-directed plans and significant barriers to achieving larger policy goals. Although consumers in more traditional models may also face similar challenges, the financial and personal health stakes for them are potentially higher in CDPs. Consumers typically bear more of the risk and responsibility for their choices and decisions in the consumer-driven models.

The difficulty of the decision tasks required of consumers and the skills needed to successfully manage within these plans may be beyond the level of effort consumers are willing to expend or may even be beyond the ability of many consumers to understand. If this is the case, then many consumers may not make the types of informed choices that are necessary to achieve either individual or policy goals.

These plans pose particular challenges for individuals with less than adequate literacy and decision skills**.** Those with fewer decision skills may be particularly disadvantaged under CDPs. Poor decisions could result in potentially serious financial consequences as well as possible health and functioning consequences. Both of these types of consequences have the potential of adding to existing health disparities.

The amount of research effort, skill, and knowledge needed to make choices could discourage voluntary enrollment into these plans by those with lower decision and literacy skills, possibly leading to an additional source of selection bias.

Much can be done to improve the way information is presented, a strategy that would help consumers navigate CDPs. Well-designed decision-support tools, evaluable information displays, and the use of other strategies that help consumers understand and weight factors key to their choices will support more informed decision making. However, given the expense and expertise required to implement these strategies, it is not clear that these actions will be undertaken. Moreover, even if they are, there is still some question as to whether they will be sufficient to achieve individual or policy goals for CDPs.

Research shows that those who are engaged in their own care, are part of decision making, and help to determine the goals of their care have better health outcomes (Von Korff, et al., 1997; Lorig, et al., 1999; Kaplan, Connolly, and Greenfield, 2000). Will this principle of involvement and control also apply to consumer involvement when it comes to provider and utilization choices within CDPs? Or is this level of responsibility unrealistic given the complexity of the information, the choices, and the system itself?

The success of the consumer-directed approach rests on a basic assumption: if consumers are given financial incentives, choices, and information to support those choices, they will take charge of their health and health care and make prudent and wise choices. Being "in charge" (or "activated") implies more than just having the right information. It means understanding and accepting a higher level of responsibility and possessing the knowledge, skills, and confidence to take this on. Will well-designed consumer information products coupled with financial incentives be sufficient to stimulate activation? There is no question that the health care system would be more appropriately used and that individual consumers would be better off if more consumers were activated. The key unanswered questions are: what will it take to activate more consumers; and what will happen to those who do not become activiated?

Finally, it will be vitally important to establish a strong research agenda to inform policy makers and stakeholders about how consumers are faring under CDPS, to identify opportunities to improve implementation approaches, and to assess the overall efficacy of this policy direction.

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Appendix: An Example of a Narrative Used in a Study with Beneficiaries:

I know as well as anyone that health care isn't cheap. I live on a fixed income, which means I can't always afford to get things fixed. I have to watch my nickels. But I've discovered, from my own experience, that cost isn't the only important consideration when it comes to choosing a health plan.

Here's how I learned. Last year, when I had some pain and swelling in my right knee, my health plan made me wait ten days to see a doctor! If it's urgent, they said, go to the emergency room. Well, I couldn't see myself doing that, so I waited the ten days. By then the knee was worse, red and more swollen. Turned out I had an advanced staph infection that required strong antibiotics to knock out. "I wish you'd come in sooner," the doctor told me! I was so mad I didn't know what to say. That was the worst, but it seemed like I always had to wait several days for an appointment with that health plan.

My best friend, though, who's on another plan, has never had to wait longer than a day or two to get in to see a doctor. And he doesn't pay anymore for his plan than I do mine. So it seems clear that some health plans make getting an appointment easy. Some even find appointment room the same day. I'm going to take a hard look at my finances to see if I can afford a different plan myself. If I can't, well, I still know that at least some plans have better waiting times than others.