2006-PB-20
December 2006

Consumer Directed Health Care

John Goodman

Abstract: Consumer driven health care (CDHC) is a potential solution to two perplexing problems: (1) How to choose between health care and other uses of money, and (2) how to allocate resources in an industry where normal market forces have been systemically suppressed. In the consumer-driven model, consumers occupy the primary decision-making role regarding the health care that they receive. From an employee benefits perspective, consumer driven health care in the broadest sense may refer to limited employer contribution or dual option plans featuring high deductible health coverage with tax advantaged savings vehicles such as Health Savings Accounts (HSAs), Flexible Spending Accounts (FSAs) and Health Reimbursement Arrangements (HRAs) (Daly, 2005). However, before we consider the solution, we must first investigate why a solution is needed in the first place.

About the Author: John C. Goodman, Ph.D. founded the National Center for Policy Analysis in 1983 and has served as President since the center's inception. Dr. Goodman is the author of nine books, including *Lives at Risk: Single-Payer National Health Insurance Around the World*; *Leaving Women Behind: Modern Families, Outdated Laws*; *Economics of Public Policy*, a widely used college textbook, and *Patient Power: Solving America's Health Care Crisis*. He has authored numerous editorials in *The Wall Street Journal*, *USA Today*, *Investor's Business Daily*, *Los Angeles Times*, *The Dallas Morning News*, *Houston Chronicle*, *The San Diego Union-Tribune*, and many others. He regularly briefs members of Congress on economic policy issues and frequently testifies before congressional committees.

The views expressed are those of the individual author and do not necessarily reflect official positions of Networks Financial Institute. Please address questions regarding content to John Goodman at john.goodman@ncpa.org. Any errors or omissions are the responsibility of the authors.

NFI working papers and other publications are available on NFI's website (www.networksfinancialinstitute.org). Click "Research" and then "Publications/Papers."

Consumer Directed Health Care

John Goodman

Consumer driven health care (CDHC) is a potential solution to two perplexing problems:

(1) How to choose between health care and other uses of money, and (2) how to allocate resources in an industry where normal market forces have been systemically suppressed. In the consumer-driven model, consumers occupy the primary decision-making role regarding the health care that they receive. From an employee benefits perspective, consumer driven health care in the broadest sense may refer to limited employer contribution or dual option plans featuring high deductible health coverage with tax advantaged savings vehicles such as Health Savings Accounts (HSAs), Flexible Spending Accounts (FSAs) and Health Reimbursement Arrangements (HRAs) (Daly, 2005). However, before we consider the solution, we must first investigate why a solution is needed in the first place.

The Need to Ration Health Care

Busy people are often unaware of how easy it is to spend other people's money on health care. Here are a few examples. The Cooper Clinic in Dallas offers an extensive checkup (with a full body scan) for about \$2,000 or more. Similar clinics have sprouted in other large cities. If everyone in America took advantage of this opportunity every year, we would increase our nation's annual health care bill by almost one-third. More than 1,000 diagnostic tests can be done on blood alone; one doesn't need too much imagination to justify, say, \$7,000 worth of tests each year. But if everyone did so, we would double the nation's health care bill.

Americans purchase nonprescription drugs almost 12 billion times a year and almost all of these are acts of self-medication. Yet if everyone sought professional advice before making such purchases, we would need 25 times the number of primary care physicians we currently have (Rottenberg, 1990). Some 1,100 tests can be done on our genes to determine if we have a predisposition toward one disease or another. At, a conservative estimate of, say, \$1,000 a test, it would cost more than \$1 million for a patient to run the full gamut. But if every American did so, the total cost would run to about 24 times the nation's annual output of goods and services.

Notice that, in hypothetically spending all of this money, we have not yet cured a single disease or treated an actual illness. We are simply collecting information. If in the process of search we actually found something that warranted treatment, we could spend even more.

One of the cardinal beliefs of advocates of single payer health insurance (and one that is shared by the advocates of the HMO form of health care delivery) is that health care should be free at the point of consumption, regardless of willingness or ability to pay. But if health care really were free, people would have an incentive to obtain each and every service so long as it had any value at all to them. In other words, everybody would have at least an economic incentive to get the Cooper Clinic annual checkup, order dozens of blood tests, check out all their genes and consult physicians at the drop of a hat.

In short order, unconstrained patients would attempt to spend the entire gross domestic product (GDP) on health care even though, as a practical matter, that would be impossible. One could argue that the current system of third-party payment automatically discourages many of these expenditures by failing to cover them. But if we continue with the current payment system indefinitely, we are still on an unsustainable path.

Government at all levels in the United States currently spends about 7.2 percent of GDP on health care, mainly on Medicare and Medicaid. This is an amount comparable to government health care spending in other countries. Yet Larry Kotlikoff and his colleagues have shown that, if benefits expand at the rate of the past 30 years and if the population ages the way demographers predict, spending will equal one-third of national income by mid-century, when today's college students reach the retirement age (Hagist and Kotlikoff, 2006). If that is not immediately alarming, note that one-third of mid-century GDP is about equal to all government spending for all purposes today. If private spending on health care keeps up with public spending, the nation will devote about two-thirds of national income to health care by mid-century — an amount roughly equal to total consumption of all goods and services today.

So in the public sphere, health care is on a course to crowd out every other government program — from education and roads and bridges to Social Security and national defense. And for the economy as a whole, health care is on a course to crowd out every other form of consumption, including food, clothing, housing, etc.

We need not endure an inordinate wait in order to see what the future has in store for us. Currently, well over half the consumption of people age 85 years of age and older is on health care.¹ By 2025, the same will be true of the entire senior population (everyone age 65 and over) (Fuchs, 2001). To say that the government path we are on is unsustainable is trivial. To ask how we are going to get off that path is a serious question which urgently needs to be answered.

At the federal level, the Social Security trustees' reports implicitly show how health care will crowd out all other government spending. Only two years ago, Social Security and

¹ In 1997, the elderly spent slightly more than one-third of their "full income" on health care. Seniors older than 84 spent about three time more per capita on health care than seniors between the ages of 65 and 74. See Fuchs (1999, 2001)

Medicare combined took in more revenue than was spent, thus contributing a small surplus to the general budget. But this year, we will need 7 percent of general income tax revenues to cover the shortfall in these programs. By 2020, we will need one in four income tax dollars to pay for the deficit in Social Security and Medicare, implying that the government will have to stop doing one out of every four things it does today. By 2030, we will need one of every two income tax dollars (and these estimates do not even include the cost of Medicaid!) (OASDI Trustees, 2005). In order to avoid this disastrous scenario, someone must be forced to choose between health care and other uses of money. The question is: who will that someone be?

Patients as Choosers. Critics of CDHC are fond of pointing out that there are times when patient choice is not desirable or appropriate. They are, of course, correct. We don't want a parent to choose not to have her child vaccinated, or an at-risk expectant mother to avoid prenatal care, or a heart patient to eschew aspirin or beta blockers. The reason: there is overwhelming evidence that the social benefits of the care exceed the social cost (Tengs et al., 1995 and Eddy, 1991). Yet instances where we can be absolutely sure that we know which alternative is the right choice are rarer than one might suppose. At the other extreme, there are literally thousands of cases where only the patient can make the right choice.

Take patients with arthritic pain. Vioxx and Bextra (before they were taken from the market) and Celebrex cost about \$800 more over the course of a year than such over-the-counter remedies as ibuprofen (Herrick, 2004, Table 3). Let us concede that, for some patients, the brand name drug is superior. Are the extra benefits of a brand drug worth \$800 a year in addition to the risks of side effects? Patients must weigh this individually.

Drugs affect different people differently. Moreover, different people have different attitudes toward risk. So it is virtually impossible for one person to make such a choice for

another. When people are spending their own money, presumably they will reveal their preferences through their actions. But most of the patients who were taking Vioxx (and should not have been) were not spending their own money. Third-party payers were paying the bill. And most of those insurance plans probably did not cover the cost of ibuprofen.

Another example is the prescription drug Clarinex, used by allergy sufferers. Some scientists claim that the over-the-counter drug Claritin is chemically the same (Schieber, 2004). Yet a year's supply of the former costs about \$949, compared to only \$280 for the latter and less than \$15 for an OTC generic equivalent.² As in the case of arthritic pain relief, many insurers will cover the cost of a brand name drug but not the OTC alternatives – inducing patients to opt for the drug with the highest social cost.

The problem with the current system is that all too often patients have no opportunity to make such choices. The reason: most of the time they are buying health care with someone else's money. Ironically, most of the people who were taking Vioxx should not have been taking it; and the best predictor of whether a patient was taking it was whether a third-party was paying the bill.³ This example is far from unique. For the health care system as a whole, patients pay only 15 cents out of pocket every time they spend a dollar, on the average. So the economic incentive is to spend on health care until its value to the patient is only 15 cents on the dollar. It's hard to imagine a more wasteful incentive structure.

Empirical Results. How do patients react when they are asked to manage their own health care dollars? We actually have far more experience with consumer directed health care

² Prices for Clarinex and Claratin are for 30 doses from Walgreens.com. The price for the generic version of Claritin (Loratadine) is for Costco.com. All prices surveyed October 7, 2005.

³ A recent study found that two-thirds of patients on Cox-2 inhibitors were not at risk for gastrointestinal conditions like ulcers or bleeding, and most of them had not tried cheaper alternatives. See Cox et Al. (2003) A separate study found that seniors with generous drug coverage but moderate risk of gastrointestinal problems were more likely to be on a COX-2 inhibitor than seniors with high gastrointestinal risk but no drug coverage. See Doshi, Brandt and Stuart (2004).

than many scholars realize. For example, we have more than a decade of experience with Medical Savings Accounts (MSAs) in South Africa, and, in this country, seven years of experience with the MSA pilot program, four years of experience with Health Reimbursement Arrangements (HRAs) and a year and a half with HSAs. The problem is, the data mainly resides with insurers who regard it as proprietary and, therefore, the results are reported by entities with a financial self-interest in the outcomes. Even so, reported results of MSAs in South Africa (Discovery Health) and HRAs in the United States (Aetna, 2006) are consistent with common sense (Matisonn, 2000, 2002). Patients cut back in areas where there is presumed to be a lot of waste and substitute less expensive treatment options for more expensive ones. That is, there are fewer trips to primary care physicians, brand-name drug purchases are down, generic purchases are up, etc.

A McKinsey study found that CDHC patients were twice as likely as patients in traditional plans to ask about cost and three times as likely to choose a less expensive treatment option.⁴ Further, chronic patients were 20 percent more likely to follow treatment regimes very carefully (McKinsey, 2005). A South African study suggests that CDHC patients can control drug costs as well as managed care, but without the cost of managed care (Matisonn, 2002). What about preventive care? McKinsey, Aetna, National Center for Policy Analysis (Discovery Health) and Humana (2005) all report an increase in preventive care – even as they report other, significant cost-reducing changes in patient behavior. Note, however, that many CDHC plans contain extra incentives to seek and obtain preventive care. Discovery Health tried to determine

⁴ Observations are of CDHC participants enrolled at least one year in plan. Due to an inadequate length of time since HSAs have existed, most of the CDHC participants in the McKinsey study (2005) were enrolled in HRAs rather than HSAs.

whether skimping on care in the short run caused higher costs in later years and found no evidence to support the claim.⁵

The Need to Allocate Resources

Many people assume that a system of national health insurance would be radically different from the American health care system. In fact, the U.S. system is far more similar to national health insurance than it is different. The reason: in our country, as in other developed countries, people primarily pay for care with their time rather than with money. In fact, as far as financial outlays are concerned, health care is almost as free in this country as it is in Canada and in Europe (Goodman, 2006).

On the average, every time Americans spend a dollar on physicians' services, only 10 cents is paid out-of-pocket; the remainder is paid by a third party – an employer, insurance company or government (Smith et al., 2005). From a purely economic perspective, then, our incentive is to consume these services until their value to us is only 10 cents on the dollar. Moreover, millions of Americans do not even pay the 10 cents. Medicaid enrollees, Medicare enrollees who have Medigap insurance, and people who get free care from community health centers and hospital emergency rooms pay nothing at the points of service. Most members of HMOs and PPOs make only a modest co-payment for primary care services. Clearly, we are not rationing health care on the basis of prices.

But if not price rationing, how do we ration physicians' services? We ration the same way other developed countries ration care. We ration by waiting. In both the United States and in Canada, the price of physicians' services is mainly set by large, impersonal bureaucracies, and the physician's time is rationed to patients based on their willingness and ability to pay for care

⁵ Apparently MSA holders are not healthier as a group. A comparison of catastrophic claims under the two different health plans did not show more catastrophic claims under the MSA plan than under the non-MSA plan. See Matisson (2000)

with time rather than money. Both countries have largely achieved what has been a goal of the political left for almost 100 years. Yet the suppression of the price system has been bad for patients in a number of ways.

Nonprice Barriers to Care. Whereas lawyers and other professionals routinely communicate with their clients by phone and by email, it is very rare for physicians to communicate that way – even for routine prescriptions (Health on the Net Foundation, 2001).⁶ Why is that? Why do doctors avoid telephone and email consultations? The short answer is, they do not get paid for these types of consultations (Wiebe, 2001).⁷ Medicare does not pay for them, nor does Medicaid or most private insurance. In general, doctors only get paid to see patients in their offices. Doctors paid under capitation arrangement would seem to have different incentives, but HMO doctors ration their time by waiting as well.

The fact that patients cannot consult with physicians by telephone or email leads to two bad consequences. First, the unnecessary visitors (say, patients who have a cold) expect at least a prescription in return for their investment of waiting time, and all too often the drug will be an antibiotic. For physicians, these prescriptions may be thought of as a convenient way of maintaining a patient clientele (Soumerai and Lipton, 1995). Were telephone consultations possible, the physician would more likely recommend an OTC remedy, thus avoiding the cost of waiting for the patient and the cost of degrading the effectiveness of antibiotics for society as a whole.

⁶ There are exceptions. It is common for people to get test results by phone and to get refills on prescriptions by phone conversations with doctors and nurses. What is rare is an actual telephone consultation. Only about 14 percent of patients exchange e-mail with their physicians. Of this, slightly less than two percent do so on a frequent basis. Survey results from Health on the Net Foundation (2001).

⁷ Among health plans that do pay, some will not compensate doctors for e-mail exchanges unless the patient has first been examined in an office. Other insurers reimburse less for e-mail exchanges than for in-person visits. See Freudenheim (2005). An exception is, Blue Shield of California, which pays physicians the same for an e-mail consultation (\$25) as it does for an office visit. See Koenig (2003). The American Medical Association has created a reimbursement code for online consultation patients, making it easier for physicians to get paid.

The second bad consequence is that rationing by waiting imposes disproportionate costs on patients who need more frequent contact with physicians. Because the chronically ill need more interactions with their doctors, they face above-average waiting costs. This may be one reason why so many are not getting the one thing they most need from primary physicians and the thing that is most likely to prevent more serious and costly health problems later on – a prescription (Kleinke, 2004).

The ability to consult with doctors by telephone or email could be a boon to the chronically ill. Face-to-face meetings with physicians would be infrequent, especially if patients learned how to monitor their own conditions and manage their own care. Remote consultations could be used to change a drug prescription or determine whether an office visit was needed.

Lack of Competition for Patients. One consequence of rationing by waiting is that the time of the primary care physician is usually fully booked, unless she is starting a new practice or working in a rural area. This means that almost all the physician's hours are spent on billable activities. Further, there is very little incentive to compete for patients the way other professionals compete for clients. The reason: neither the loss of existing patients nor a gain of new patients would affect the doctor's income very much. Loss of existing patients for example, would tend to reduce the average waiting time for the remaining patients. But with shorter waiting times, those patients would be encouraged to make more visits. Conversely, a gain of new patients would tend to lengthen waiting times, causing some patients to reduce their number of visits. Because time, not money, is the currency we use to pay for care, the physician doesn't benefit (very much) from patient-pleasing improvements and is not harmed (very much) by an increase in patient irritations.

This insight may explain why doctors in some areas now refuse to take new Medicare patients.⁸ Assuming that retirees have a lower opportunity cost of time, odds are they are willing to out-wait the nonelderly patients. And since Medicare pays at a lower rate than private insurance, such crowding out actually lowers the physician's income. Medicaid typically pays even less than Medicare and since Medicaid patients also tend to have a lower-than-average opportunity cost of time, small wonder that many doctors refuse to see any new Medicaid patients.⁹

Rationing by Waiting vs. Rationing by Price

Virtually all of these features of our health care system discussed above are the direct result of the way in which we pay for health care, especially the way we pay doctors. That is, we compensate physicians in ways that are different from the way we pay for other professional services and those differences create problems in the medical marketplace that do not arise in other markets. The principal payment methods, moreover, are not the natural result of free market forces. They are instead the product of distortions created by public policies. And in most cases, mistakes embedded in the public policies and in the payment mechanisms reflect a failure to understand the economics of time.¹⁰

Would physicians practice medicine differently if they were paid differently? There is ample evidence that the answer is yes. Unlike other forms of surgery, the typical cosmetic surgery patient can (a) find a package price in advance covering all services and facilities, (b) compare prices prior to the surgery and (c) pay a price that is lower in real terms than the price

⁸ According to an American Medical Association survey, about 30 percent of physicians limit the number of new Medicare patients they will accept — or do not accept Medicare patients at all. See Hawryluk (2002).

⁹ According to a recent survey by the Medicare Payment Advisory Commission more than 30 percent of physicians refuse to access any new Medicaid patients (Hackbarth, 2002).

¹⁰ On the general economics of time, see DeVany and Saving (1983).

charged a decade ago for comparable procedures – despite the technological innovations in the interim (Herrick, 2003).

Ironically, many physicians who perform cosmetic surgery also perform other types of surgery. The difference in behavior is apparently related to how they are paid. A cosmetic surgery transaction has all the characteristics of a normal market transaction in which the seller has a financial interest in how all aspects of the transaction affect the buyer. In more typical doctor-patient interactions, doctors are not paid to be concerned about all aspects of care and therefore typically ignore the effects on the patient of the cost of time, the cost of drugs, and other ancillary costs. Note, this holds for HMO doctors as well as fee-for-service doctors. What is true for U.S. doctors in general is also true of doctors who practice in the government-run health systems of other developed countries.

References

Aetna, (2006, October 2). Aetna Releases Broadest Study To Date Of Consumer-Directed Plans .

Web site: http://www.aetna.com/news/2006/pr_20061001.htm

Agrawal , V., Ehrbeck, T., O'Neill Packard, K., and Mango, P. (2005, June). Consumer-

Directed Health Plan Report - Early Evidence is Promising: North American Payor
Provider Practice. McKinsey & Company. Web site:

http://www.ahipresearch.org/pdfs/ConsumerDirectedHealthPlanReport_Promising.pdf

Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance

Trust Funds, (2005, March 23). 2005 Annual Report of the Board of Trustees of the

Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds, from

The 2005 OASDI Trustees Report Web site: <http://www.ssa.gov/OACT/TR/TR05/>

Cox, E et al (2003). Prescribing COX-2s for Patients New to Cyclo-oxygenase Inhibition

Therapy. *American Journal of Managed Care*. 9, 735-742.

Daly , T (2005, January 24). Who's Really Driving Consumer Driven Healthcare. From

Insurance Journal Web site:

<http://www.insurancejournal.com/magazines/west/2005/01/24/features/51351.htm>

DeVany, A, and Saving, T (1983). The Economics of Quality. *Journal of Political Economy*. 91,

979-1000.

Doshi, J, Brandt, N, & Stuart, B The Impact of Drug Coverage on COX-2 Inhibitor Use In

Medicare. *Health Affairs*, Web site

<http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.94v1/DC1>.

Eddy, D (Ed.). (1991). *Common Screening Tests*. Philadelphia: American College of Physicians.

- Freudenheim, M. Digital Rx: Take Two Aspirin and E-Mail Me in the Morning. (2005, March 2). *New York Times*.
- Fuchs, V (2001). The Financial Problems of the Elderly: A Holistic Approach. National Bureau of Economic Research, NBER Working Paper 8236.
- Fuchs, V (1999). Provide, Provide: The Economics of Aging. In Rettenmaier, A. and Saving, T., Eds., *Medicare Reform: Issues and Answers*. Chicago: U of Chicago P. 15-36.
- Goodman, J (2005). Time, Money and the Market for Drugs. National Center for Policy Analysis Web site: <http://www.ncpa.org/pub/special/20051205-special.html>.
- Hackbarth, G (2002). MEDPAC Recommendations on Physician Payment Policy. Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives Web site: http://www.medpac.gov/publications/congressional_testimony/022802_SGR.pdf
- Hagist, C and Kotlikoff, L (2006). Health Care Spending: What the Future Will Look Like. National Center for Policy Analysis, NCPA Policy Report 286. Web site: <http://www.ncpa.org/pub/st/st286/>
- Hawryluk, M (2002, October 21). Physician Payment Crunch: Medicare Cuts Hit Medicaid Access. *American Medical News*, from <http://www.ama-assn.org/amednews/2002/10/21/gv111021.htm>
- Health on the Net Foundation, (2001, Feb/March). Evolution of Internet Use for Health Purposes. HON Surveys Web site: <http://www.hon.ch/Survey/FebMar2001/survey.html>
- Herrick, D (2004). Shopping for Drugs: 2004. National Center for Policy Analysis, NCPA Policy Report 270. Web site: <http://www.ncpa.org/pub/st/st270/>.
- Herrick, D (2003). Why Are Health Care Costs Rising? National Center for Policy Analysis, NCPA Brief Analysis 437. Web site: <http://www.ncpa.org/pub/ba/ba437/>.

- Humana Inc., (2005, June). Health Care Consumers: Passive or Active?. Web site:
<http://www.humana.com/visitors/pdf/victory.pdf>
- Kleinke, J (2004). Access Versus Excess: Value-Based Cost Sharing for Prescription Drugs.
Health Affairs. 23, 34-47.
- Koenig, D. A Few Doctors Seeing Patients Online. (2003, December 21). *Akron Beacon Journal*.
- Making a Difference: Aetna HealthFund. Aetna, September 2006.
- Mattison, S (2002). Medical Savings Accounts and Prescription Drugs: Evidence from South
Africa. National Center for Policy Analysis, NCPA Policy Report 254. Web site:
<http://www.ncpa.org/pub/st/st254/>.
- Mattison, S (2000). Medical Savings Accounts in South Africa. National Center for Policy
Analysis, NCPA Policy Report 234. Web site: <http://www.ncpa.org/pub/st/st234/>.
- Rottenberg, S (1990). Unintended Consequences: The Probable Effects of Mandated Medical
Insurance. *Regulation* 13, 27-28.
- Schieber, S (2004). Why Coordination of Health Care Spending and Savings Accounts is
Important. From Watson Wyatt Worldwide Web site:
<http://www.watsonwyatt.com/research/whitepapers/wprender.asp?id=wp-22>
- Smith, C et al (2005). "Health Spending Growth Slows in 2003. *Health Affairs* 24, 192.
- Soumerai, S and Lipton, H (1995). Computer-Based Drug-Utilization Review: Risk, Benefit, or
Boondoggle? *New England Journal of Medicine* 332, 1641-1645.
- Super, N (2005). Medicare Physician Payment: How to Build A More Efficient Payment System.
Subcommittee on Health, House Committee on Energy and Commerce, U.S. House of
Representatives Web site:
<http://energycommerce.house.gov/108/Hearings/11172005hearing1718/Super.pdf>

Tengs, T et al (1995). Five-Hundred Life-Saving Interventions and Their Cost-Effectiveness.

Risk Analysis 15, 369-390.

Wiebe , C (2001). Doctors Still Slow to Adopt Email Communication. *Medscape Money &*

Medicine 2, <http://www.medscape.com/viewarticle/408356>.