When the Patient is the Payer:
Consumer-Directed Health Care and Patient Advocacy

Joseph Coletti

Generally speaking, when a person uses someone else's money to buy something for another person, the purchaser does not think much about cost or quality. When that person uses someone else's money for himself, the purchaser cares a lot about quality and less about cost. When that person uses his own money for somebody else, he cares a lot about cost and less about the appropriateness of his spending. Only when a person uses his own money on himself do the incentives align for the purchaser to seek both low cost and high quality. It follows, then, that the best advocate for a patient is the patient himself or a trusted family member, and the best way to advocate for better care is to control the payment for care. This is the simple premise of consumer-directed health care.

With one-fifth of consumers now enrolled in some form of consumer-directed health care plan and trends continuing toward more consumer direction, it is worth examining this premise. Experience, budget constraints, and psychology offer reasons to expect better health results at a lower cost if patients can direct their own dollars and make their own decisions about their care. Before exploring those reasons, it is important to clarify what we mean by consumer-directed health care and how it differs from other options.

Distortions in the Health Care Market

As many as eight million people in North Carolina do not pay directly for their health insurance or health care. Medicare covers almost every North Carolinian over 65. Three-fifths of North Carolinians under the age of 65 get insurance through an employer, and one-fifth are enrolled in a government program such as Medicaid. The other one-fifth are either uninsured or purchase insurance on their own.[2] One-quarter of the uninsured are likely to be eligible for a government program.[3] With so many people covered by third-party payers, it should not be surprising that out-of-pocket costs have fallen from one of every two health care dollars spent in 1960 (47%) to just one of every eight today (12%).[4]

Arnold Kling labels the current system "insulation," not insurance.[5] When health care consumers pay 12 cents of each dollar for their health care, the care they purchase only has to produce a little more than 12 cents of benefits to be worth the perceived cost. If we had the same deal at restaurants, a $24 family dinner at McDonald's would cost less than $3. Dinner for two at Ruth's Chris Steak House would be about $12, but reservations would be impossible to get.

What is Consumer-Directed Health Care?

Consumer-directed health care is most closely associated with high-deductible health plans (HDHPs) and health savings accounts (HSAs). Other financing arrangements, such as flexible spending accounts (FSAs) and health reimbursement arrangements (HRAs), are also available. Each of these adapts, within the regulatory limits placed on it, to meet the demands of the market. But these plans are only half-measures to true consumer direction and each engenders criticism for how it currently functions. The legal restrictions on HSAs—tying them to certain high-deductible policies and placing severe limits on the amount an individual can contribute in a year—makes them unattractive and inappropriate for many who could otherwise benefit. The "use it or lose it" nature of FSAs can lead to wasteful expenditures as the annual deadline approaches. The inability of employees to contribute to their HRAs makes this vehicle less effective than it could be. Also, both FSAs and HRAs are not portable from job to job.

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An important part of the solution to the above challenges would be to eliminate tax law provisions that date back to the

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1940s. These provisions give tax privileges to employer-sponsored insurance over individually-purchased insurance. A number of proposals from the left[6] and the right[7] would eliminate the tax disparity between employer-sponsored insurance and individual spending on health care. Any of these proposals, as well as the straightforward but politically difficult proposal to simply cap or end the tax break for employer contributions without offsetting the tax increase,[8] would put all health care dollars on equal footing.

Equalizing tax treatment, if it led people to purchase insurance in the individual market, would also provide more stable coverage for those in poor health who lose their jobs.[9] Only 9% of unemployed workers decide to continue their employer-sponsored insurance coverage, in part because of the cost.[10] Many of those 9% are likely to have a medical need, such as pregnancy, that exceeds the cost of coverage. Others may be more willing to take the risk of being uninsured in order to avoid high health insurance costs.

Beyond choice of insurer, consumers should also have equal tax treatment if they purchase health care on their own without insurance. My family has a high-deductible insurance policy that still covers too many things and is too expensive, but we use our health savings account to see a doctor who does not take insurance, so we file our own claims. Why should taxes on that choice and the resulting care depend on the type of insurance I purchase? It's possible that removing the tax penalty for directly purchasing care can improve the doctor-patient relationship while eliminating dependence on employers and insurers.

Three Main Reasons to Select Consumer-Directed Health Care Plans

Reason #1: Experience in other areas

Only in education have government regulations and tax policy limited consumer choice as much as in health care. In no other industry do third-parties—whether government, employers, or insurance companies—pay most of the cost. But even this distortion is not found everywhere within the health care industry. Dentistry, cosmetic surgery, laser eye surgery, cash-only practices, and medical tourism all rely more on consumers who pay for their own treatment. In these areas, unlike in the majority of health care, prices have fallen while quality has improved. Consumers or their family members act as their own advocates and therefore pay attention to the value they get for the dollars they spend.

Duke law professor Clark Havighurst has argued that significant changes in health care have occurred precisely in those areas where consumers spend their own money and direct their own care. That is, practices that meet the needs of those with high-deductible plans or no insurance have been the most innovative.[11] In addition to the practices listed above, consider the creation of convenience clinics or the proliferation of $4 prescriptions. Few people with more traditional copay-only insurance policies demanded these innovations, although they have clearly benefited from their use.

When consumers are in control of their own dollars, they seek more information and find cost savings that benefit everyone. For example, Aetna found that consumers with HSAs were similar in age and family size to those with more traditional plans but accessed online tools more than twice as often and changed their health care consumption in such a way that Aetna had savings equivalent to "$1 million per 1,000 employees over a three-year period while still maintaining quality care."[12]

Markets create a need for information. When consumers control how, when, and where they spend their health care dollars, they care more about cost and quality of care. Consumers have not been in a position before now to demand information because cost control is not important under indemnity plans and choice is limited under HMO and PPO plans.

Reason #2: Budget constraints

Health care is a scarce resource. The supply of doctors is not infinite nor is the time or financial resources of doctors, patients, and those who pay for care. As a result, care must be rationed and somebody must decide what care is not worth providing or consuming. When a state or federal government decides, it can ration care directly on the demand side by denying treatment. More often it relies on low reimbursement rates for Medicare or Medicaid, strict licensing laws, certificate of need rules, preferred drug lists, and other regulations to limit the payment for or supply of care.

Private insurers and Medicare presently look to pay for performance, evidence-based medicine, or comparative-effectiveness research to help determine what care is worth purchasing. While established best practices can be overturned with new research, formal rules and regulations based on existing practices may not change as quickly. In addition, there are always outliers who do not respond or who have adverse reactions to established protocols. Finally, individual risk preferences vary so that one person may prefer a less invasive procedure that treats most of the problem to a more invasive one that treats all of it.

Much of the empirical research into consumer-directed health care has focused on whether persons enrolled in consumer-directed plans can afford coverage or if they delay care. No research exists on actual health outcomes tied to these determinants. The closest we have is the RAND Health Insurance Experiment,[13] which found that patients with higher deductibles delayed treatment and took other cost-saving steps, but had similar health outcomes as patients with lower deductibles who used more care. Within Medicare, the Dartmouth Atlas Project[14] found that costs in the top-spending regions were 30% higher than in low-spending regions, again with generally similar outcomes.

Reason #3: Human psychology

Consumer-directed health care protects individual risk preferences and provides the best way to accommodate new information in health care decisions. Just as consumers will

seek information if they have control over a decision so, too, will they have more incentive to correct a bad decision they made.

Consumers will make mistakes about care, even if they get the best information and advice. It happens. In most cases the damage of that mistake will be limited to the person who made the mistake. The damage from mistakes by insurance companies, employers' human resource staff, and government regulators, however, can hurt dozens, hundreds, or even thousands of people. In general the person making a mistake can see the effects more quickly and act on them sooner than can an insurance company or a government official.

Imperfect people with imperfect information also make company and government policies. Those policies affect more people, have more ambiguous impacts, and are harder to change. Moreover, an examination of federal safety regulations found that there was no pattern to the balance of risks and benefits allowed. In the case of airbags, regulators even mandated changes with minimal benefits and significant risks.[15] In short, regulators, employers, and insurance claims adjusters do not have the same incentives as consumers themselves to make the right decision.

Difficult Patients or Demanding Consumers?

Moving to consumer-directed care could also change the attitudes of providers toward their patients. Anecdotally, many doctors consider patients who ask questions and do their own research "difficult." These patients may challenge their diagnoses, request the newest drugs they have seen advertised, or ask questions about something they read online. They may go to a doctor halfway across the country who specializes in conditions such as theirs.

Sometimes the patient is wrong and, for example, his self-determined dosage schedule for insulin does not help him control his blood sugar. Other times the patient is right and, with the right treatment regimen, she can bear children despite scleroderma.[16] The important thing is that the provider-patient relationship should be collaborative, with proper deference accorded to both the medical training of the professional and to the patient's personal experience and preferences.

Unfortunately, most physicians have little time to talk with their patients. Insurance companies will pay for drugs and tests, but not talking time. The reimbursement rates, payment delays, unpaid invoices, and administrative headaches of Medicare and private insurance put more pressure on doctors to churn through dozens of patients a day.

Insurance companies have their own voicemail maze for patients to navigate, so it is difficult to rely on them for advocacy. On top of this, a patient's employer pays the premium in most cases, not the patient herself. Elected officials only have so much leverage over government health care bureaucracies and none at all over providers themselves.

That leaves the patient. Consumer-directed health care can give patients leverage with their employers, doctors, and insurers. That some consumers have been unhappy with their consumer-directed health plans should not be surprising because some of the decisions to adopt such plans are made by employers and so are subject to the same pitfalls described above. When patients control their own spending, however, they become their own advocates. They no longer have to seek permission and fight on two or three fronts—with the doctor about a treatment plan, the insurance company or government about what was or was not covered, or the employer about the poor plan design and high cost of the insurance.

To paraphrase from another industry: when doctors and insurers compete for your business, you win. **NCMJ**

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