

The Case for Consumer-Driven Health Care

WITH THE RETURN OF DOUBLE-DIGIT annual increases in the cost of health care, employers and health plans are again searching for ways to contain it. But most techniques for controlling or reducing costs have relied on third-party intervention to reduce the demand for care. The patient or end-user of health care has become increasingly removed from the decision-making process and the financial consequences of those decisions. The new consumer-driven health care products begin to shift the responsibility for health care decisions and the financial consequences of those decisions back where they belong—with the consumer.

This shift attempts to build a more rational economic model in health care. Although we'd like to think of the health care system as altruistic, the reality is that health care delivery and financing is a business. At their most basic level, the transactions in health care occur between a provider of care and a patient. It's this interaction that ultimately determines the supply and demand for health care services. As we've found, it's quite difficult for a third party to exert much control over such a system.

Some suggest that health care is fundamentally different from other parts of the economy and that the usual supply and demand considerations don't apply. The core premise of this position is that most health care is essential and not discretionary, like many other purchases. While this is true for some treatments and services (e.g., chemotherapy for cancer), others are indeed discretionary and driven by either provider or consumer preferences. A good example of the latter is the still too common practice of prescribing antibiotics for viral infections, which provides no real medical value (and potentially can cause

harm) but may meet a patient preference or expectation.

John E. Wennberg and others ("Geography and the Debate over Medicare Reform," *Health Affairs* web exclusive, Feb. 13, 2002) suggest that much of the variation in the cost of Medicare in different regions of the United States is explainable by differences in "supply-sensitive" care. This validates the general

reasoning of many actuaries—that an increased supply of health care providers leads to increased utilization. Furthermore, the researchers found little evidence that increasing the quantity of care produces better health status or outcomes. Clearly, not all medical care is necessary.

What Is Consumer-Driven Health Care?

A variety of terminology describes the new consumer-oriented health plans: defined contribution, consumer-centric, consumer-directed, or consumer-driven plans. Of these terms, all are interchangeable, with the exception of "defined contribution." While consumer-driven plans frequently include a component of defined contribution, a defined contribution plan is not necessarily consumer-driven.

There are two key components that define a consumer-driven plan. First, the plan needs to create financial incentives for a plan member to use care appropriately. Second, the plan needs to include tools and resources to assist a member in becoming a better consumer of health care.

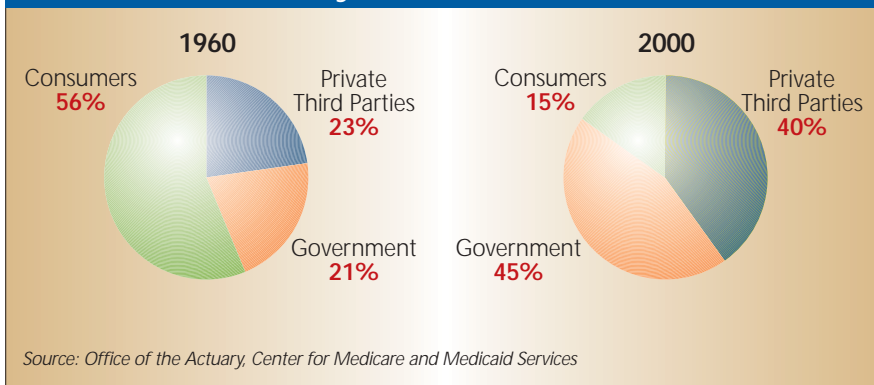
There are many ways of addressing the first compo-

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Who Pays for Health Care?



ment. The most prevalent plan design includes an employer-funded, first-dollar personal care account (PCA) that covers routine, discretionary care, and a high-deductible health coverage plan that covers catastrophic or high-cost events. Typically, any unused amounts in the PCA can be rolled over and used in subsequent plan years.

Another plan design includes a broad menu of plan choices with varying contribution levels that an employee can choose from at enrollment. This is generically a defined contribution approach, although it's often marketed as consumer-driven. This approach allows only for an annual choice between traditional plan designs, so the true level of consumerism involved is relatively low.

Such designs don't represent a significant change. While flexible benefit designs, which have been around for many years, may offer employees more choices at enrollment, they don't address the core economic issues associated with third-party payment systems. A consumer-driven system requires that financial incentives apply not just once a year, but at every interaction between patient and provider.

In other consumer markets, I make choices with each transaction rather than once a year. For example, when buying groceries I choose not only the supermarket but also the items I put in my cart, based on my current needs and day-to-day convenience. I may choose a store close to home on one day and one that's near my office on another. In either case, I choose what to buy based on clear cost/quality trade-offs: steak versus chicken or store brand versus national brand.

A single annual choice is not truly consumer-driven—for groceries or for health care.

Because today's health care market is not consumer-friendly, a key component of consumer-driven designs is a set of tools to assist people in understanding the complex health care system. There is currently no mechanism readily available to determine the cost of health care services as there is in other areas of the economy. In most other purchasing decisions, there is a great degree of transparency in the price and quality trade-offs associated with competing alternatives. Because this data isn't available elsewhere, consumer-driven plans have developed comprehensive tools to bring this information directly to consumers.

Why It Works

It's a common actuarial assumption that the use of health care services decreases as cost sharing increases. The typical consumer-driven plan design takes advantage of this by offering a limited first-dollar benefit account that employees can use for routine medical expenses. These dollars can be used in the current plan year or rolled over for future expenses. In many cases, employers have also expanded the scope of eligible expenses that may be reimbursed from this account to include less commonly covered items such as dental or vision care.

The ability to roll-over balances encourages employees to treat this account as if it were their own money. Unlike other out-of-pocket expenses that often must be paid from after-tax funds, this account retains the favorable tax treatment of employer funds used to pay for health care.

If employees view this account as being their own money, similar reductions in utilization are possible, as with other higher cost-sharing plans. Effectively, this plan design includes the same tax efficiencies and perceived value as a traditional plan, but with an expected utilization pattern similar to a higher cost-sharing plan.

Besides the actuarial arguments for this approach, we can also look at some examples of other health services that have not traditionally been covered extensively by employee benefit plans. Vision care is one example of a health service that many people pay for largely out of their own pocket. Vision care has not been subject to the same cost inflation as general health care, even though eye exams and prescriptions are provided by skilled professionals and are just as necessary for good health as many other services.

Vision care services tend to be highly competitive (many choices of provider), price transparent (prices are frequently advertised or plainly displayed), and generally very convenient for the consumer (available evenings and weekends for no additional charge). Despite being a necessary service (if you need vision correction it's difficult to do without it), the market for vision care is very different from what we see with other forms of health care. If we create a consumer market for health care, would we see similar results? On the contrary, if all employers were to offer coverage for vision services, would we expect to see increased utilization? More providers?

Even when relatively expensive new technology becomes available, a different pattern emerges in the vision care market than elsewhere in health care. The cost of laser vision correction surgery has continued to drop in the past few years, despite continuing improvement in the technology and expensive equipment. This is precisely the pattern we see in any other consumer market as technology improves. In health care, however, we have become conditioned to new technology increasing costs. Is this because health care is the only market where third-party reimbursement rather than market competition de-

termines the pricing of new services?

A similar market dynamic occurs with formerly prescription medications that become available over the counter (OTC). Examples of this include acid reducers (e.g., Tagamet, Zantac, etc., now also available as generics) and more recently one non-sedating antihistamine (Claritin). In both cases, the per-unit cost of these medications dropped precipitously when introduced as OTC versions. In the case of the acid reducers, the OTC versions were less than full prescription strength, so the comparison isn't exact. But the antihistamine is identical to the prescription strength and costs at least 60 percent less per unit than the prescription version. Clearly, the economics of a retail OTC drug, even an OTC drug identical to its prescription version, are very different when the employer or health plan is no longer paying most of the cost.

Unwanted Side Effects

While we've certainly seen great advances in treatment and medical technology over the past few decades, we haven't seen advances in quality, cost, and convenience equal to those observed in other areas of the economy. The third-party payment system in health care tends to restrict the entrepreneurial possibilities that are present elsewhere in the economy. Potential health care business models are constrained not only by the usual business considerations (is there sufficient demand for the service at a profitable price?) but also by whether a third party will consider the service eligible for payment by a health plan. This severely limits the universe of viable health care business models.

This "one size fits all" approach to provider payment also limits creativity in the provision of care. Even if more convenient or higher quality health care services were made available, they'd be limited by the current practice of paying all providers the same negotiated rate for a given service (e.g., a routine office visit). In this system, it's difficult for a patient to make informed choices based on perceived quality differences. It's also difficult for providers to differentiate them-

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selves and compete based on quality or convenience.

Most Americans would probably consider our health care system to be of high quality, especially when viewed strictly from an access-to-care perspective. If other metrics are considered, such as convenience, accuracy, error rates, or other common quality measures, the picture is much less positive. Few would regard our system as especially convenient for the patient or even free of avoidable errors. Who hasn't waited in a provider's office even with a scheduled appointment, or heard horror stories of medical errors (e.g., drugs incorrectly prescribed, surgery performed on the wrong limb, etc.)? Few of us would accept this level of quality in other consumer markets. Why be satisfied with it in our health care system?

In an increasingly 24-7 economy, health care is still largely available from 9 a.m. to 5 p.m. Monday through Friday; by appointment only. What if the everyday convenience we take for granted elsewhere in the economy were also available in health care? Without the ability of individual consumers to place an economic value on convenience or other important quality metrics, coupled with the ability of providers to compete on price and quality, we may never know.

Why Should We Do It Now?

Many of the problems we face in health care today can be traced to the prevalence of the third-party payment system itself. Both patients and providers are largely disconnected from the basic economic transactions that occur at the point of care. This

leads to predictable results: increased demand from patients who are insulated from the true cost of care and increased supply by providers who are shielded from true market competition.

Those who say consumer-driven health care can't work should recall that the industry has often been wrong before. It was once thought that group insurance wouldn't work and would result in severe financial losses without individual underwriting. Similarly, managed care provisions such as utilization review were considered by some to have little real impact on utilization of care. (Measured effects were due to selecting healthier risks.) Certainly group insurance has had a long history of success, and most would now agree that managed care methods have been successful in reducing at least some excess utilization.

It was also once thought that first-dollar benefits without deductibles would result in over-utilization due to increased moral hazard. According to data from the Centers for Medicare and Medicaid Services (Figure 1), the share of total health cost paid by consumers has dropped from 56 percent in 1960 to only 15 percent in 2000. It may be that this one was actually true—it just took us a few decades to figure it out.

It's natural to support the status quo in any system, and changes are often strenuously opposed until they're proven. Consumer-driven health care may not solve all our health care problems, but it's a step in the right direction. Clearly, maintaining the status quo (double-digit annual cost increases for the foreseeable future) is not an acceptable alternative.

Early results at my company suggest that significant changes in behavior are already happening with these new designs. If we can create consumers in health care, it may very well pay dividends throughout the system in increased satisfaction, convenience, and quality. Consumer-driven markets work everywhere else in the economy—from fast food and computers to housing and automobiles. Why can't they work in health care too?