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CONSUMER-DRIVEN HEALTH CARE: LEGAL AND POLICY IMPLICATIONS

A SYMPOSIUM INTRODUCTION AND OVERVIEW

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INTRODUCTION

Politicians, social commentators, and academics have talked for years about the “crisis” facing health care in this country. Today, perhaps because we have heard the word used so often and for so long, or because we think we will “muddle” through somehow like we always have, or because even though opinion polls regularly reflect the public’s concerns about health care our national attention span for any given issue is remarkably short, we seem to lack the interest or will to really address this crisis.

Still, all the signs of a real problem seem to remain—and worsen. Health care spending continues to rise at a rate far in excess of general inflation, consuming an ever-increasing portion of our nation’s resources.1 While we possess the most scientifically and technologically sophisticated health care infrastructure of any nation, we seem unable to consistently deliver high-quality, basic health services to all patients. As the costs to employers to provide health insurance benefits for their employees continue to rise, forcing many to curtail or eliminate those benefits, the number of Americans without health insurance increases.2 Without insurance, people simply delay getting the care they need. When their illnesses finally can no longer be ignored, too

1 In 2004, the United States spent $1.877 trillion on health care or $6,280 per person, up 7.9% from 2003. This accounted for 16% of the nation’s Gross Domestic Product (GDP). Projections for 2006 set health care spending at over $2.1 trillion (16.5% of the GDP), a per capita rate of $7,110. Christine Borger et al., Health Spending Projections Through 2015: Changes on the Horizon, 25 HEALTH AFFAIRS (Web Exclusives) w61 (2006).

2 In 2006, the average employer premium for health insurance rose 7.7%, down from 9.2% in 2005. By comparison, the economy grew at an annual rate of 5.9%, while workers’ wages rose by 3.8%. Also, 2006 marked the fifth year in a row that employees have been asked to pay a greater portion of the cost
often they seek medical care at the emergency room of one of our already over-stressed hospitals.

How we arrived where we are today is a long and complicated story that others have told. However, the seeds of what we now have were, at least in part, sown in the 1940s and 1950s in the system of private, employer-based health insurance that we fashioned. Built upon fee-for-service reimbursement, which paid hospitals and physicians the “reasonable cost” for whatever care they provided, this financing system gave “providers little incentive even to consider the costs of the services they delivered [and] ... [i]n fact ... created economic incentives to provide marginally beneficial and even unnecessary care.” So long as insurers could pass premium increases on to employers, who in turn built those added costs into the prices paid for their goods and services, there was little impetus to change things. Further, consumers were largely insulated from the real costs of their health care. Government tax policy that subsidized generous employer-provided health insurance coverage led consumers to focus attention on the extent of the health care benefits to which they were “entitled” and not on the cost of that care.

As a result of this financing structure, those who made purchasing decisions regarding health care services, namely physicians and their patients, had little or no reason to consider the costs of the services they were buying—buying with, what seemed to be, someone else’s money. The hard reality—that this financing structure was not sustainable—would only emerge over time and the search for “solutions” would begin.

Over the years, the solutions we have tried for the health care crisis, from comprehensive health planning to fee freezes and prospective payment, from managed competition to managed care, have all made differences, some more or less significant than others. Ultimately however, each solution, whether alone or in combination, has failed to produce a stable health care system capable of consistently providing fair and convenient access to high-quality, affordable health care for all Americans. Now, the most current approach to capture the attention of employers, insurers, politicians, and health policy analysts is “consumer-directed” or “consumer-driven” health care.


In August of 2006, the United States Census Bureau reported that 46.6 million Americans lacked health insurance coverage in 2005, an increase of 2.9% from 2004. The percentage of the American population without health insurance rose from 15.6% in 2004 to 15.9% in 2005. Jessica Zigmond, 46.6 Million and Counting, 38 MODERN HEALTHCARE 7 (Sept. 4, 2006).

3 Id.
4 Id.
5 Id.
I. THE WHAT AND WHY OF CONSUMER-DRIVEN HEALTH CARE

The term “consumer-driven health care” is used to describe a financing structure for health care services that involves an amalgam of elements, all of which are designed to focus on “consumer choice.” The underlying rationale for consumer-driven health care derives from the simple, yet powerful, idea that what works in other sectors of our economy to drive pricing, quality, and service, namely consumer choice, should also do so in the health care financing sector. Consumer-driven health care seeks to harness the power of the informed, market-focused, self-motivated consumer to reshape the structure of health care finance in America.

To achieve this, a consumer-driven health care plan generally includes high-deductible health insurance coverage to protect the consumer from catastrophic medical care costs. With such a high-deductible plan, the consumer does not have first-dollar coverage and is responsible for paying out-of-pocket the costs for most routine care directly to the provider. As a result, in theory, the consumer has a strong incentive to examine treatment alternatives and prudently shop for health care services at affordable prices.

To encourage consumers to set aside money to be used to meet their health care expenses, consumer-driven health plans also typically include some form of tax-advantaged savings account that allows the consumer to save money for future health care needs. Also, generally any unused funds in this account can accrue tax-free over time, further encouraging the consumer to save sufficient money to meet out-of-pocket costs. Additionally, in a consumer-driven health care plan, to the extent a third party such as an employer or government agency helps fund the consumer’s coverage, it does so with a “defined” contribution; a preset, fixed amount of money. Finally, consumer-driven health care plans seek to support and facilitate consumer choice by providing timely access to relevant and useful information relating to the health care coverage decisions the consumer must make.

Consumer-driven health care received a major boost from Congress in the 2003 Medicare Prescription Drug, Improvement, and Modernization Act (MMA). The MMA allowed consumers to establish “health savings accounts” (HSAs) to enable them to save money, tax-free, for their health care expenses, thereby encouraging the public to adopt the idea of consumer-driven health care. Since then, interest in consumer-driven health care has grown. The federal Government Accountability Office (GAO) released a report in April of 2006 entitled “Consumer-Directed Health Plans: Small but Growing

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Enrollment Fueled by Rising Cost of Health Care Coverage.” In this report, the GAO found that, from January of 2005 to January of 2006, the number of enrollees and dependents covered by a consumer-driven plan increased from about 3 million to between 5 and 6 million. Although this is still only a small portion of the 177 million Americans with private health insurance, the GAO found that interest among insurers and employers in consumer-driven health care is steadily increasing.

Another GAO report released in August of 2006, “Consumer-Directed Health Plans: Early Enrollee Experiences with Health Savings Accounts and Eligible Health Plans,” offers additional insights regarding consumer-driven health care. The GAO conducted several focus groups with plan enrollees. The GAO found that most enrollees (who generally had higher incomes than comparison groups) indicated they had a positive experience with their consumer-directed plan. However, most also said they would not recommend such a plan to all consumers. As the GAO report put it, while “[m]ost participants reported satisfaction with their HSA-eligible plan and account [and] would recommend HSA-eligible plans to healthy consumers,” they would not recommend them “to people who use maintenance medication, have a chronic condition, have children, or may not have the funds to meet the high deductible.” Further, although the GAO focus group participants generally understood their basic plans, few said they actually spent time researching health care costs, with the exception of prescription drugs.

Beyond the beginnings of consumer-directed health plans in private health care financing arrangements, this approach has also begun to appear in other settings. For example, a Medicaid demonstration project in several states has introduced a consumer-directed plan for Medicaid beneficiaries in need of long-term care. Beneficiaries receive an allowance based on their care needs and can then use the allowance to hire whomever they wish to provide their care, including relatives or friends. Further, they can use the allowance to pay for approved living condition enhancements, such as a wheelchair ramp. The results of the demonstration reveal a high satisfaction rate among beneficiaries, as well as improved quality. The impact of this approach on the costs of long-term care for the beneficiaries is not clear. One
study found the consumer-directed plan initially more expensive than traditional care approaches, although the cost differential diminished after the first year of the demonstration plan.\textsuperscript{15}

\section*{II. THE 2006 SOUTHERN ILLINOIS HEALTHCARE/SOUTHERN ILLINOIS UNIVERSITY HEALTH POLICY INSTITUTE}

In the context of this emerging interest in and experimentation with consumer-driven health plans, the 2006 Southern Illinois Healthcare/Southern Illinois University Health Policy Institute, “Consumer-Driven Health Care: Legal and Policy Implications,” was held at the Southern Illinois University School of Law in Carbondale, Illinois on May 19, 2006.\textsuperscript{16} The speakers for the Institute were: Regina E. Herzlinger, the Nancy R. McPherson Professor of Business Administration at the Harvard Business School in Cambridge, Massachusetts; John G. Goodman, President of the National Center for Policy Analysis in Dallas, Texas; Todd Sloane, Assistant Managing Editor of \textit{Modern Healthcare} magazine in Chicago, Illinois; Sara Collins, Senior Program Officer at the Commonwealth Fund in New York City; and Arnold J. Rosoff, Professor of Legal Studies and Health Care Systems at the University of Pennsylvania’s Wharton School in Philadelphia, Pennsylvania.

The presentations at the Institute critically and thoughtfully examined consumer-driven health care from a range of perspectives, including those of consumers, providers, employers, third-party payors, and government agencies. The speakers’ views differed, at times sharply, as to the merits of consumer-driven health care as a solution to our health care crisis, but all agreed that discussion and dialogue were critically important. To augment the presentations at the Institute and to expand the audience for the critical analysis provided by the Institute’s speakers, this symposium issue of the \textit{Journal of Legal Medicine} includes articles from several of the participants in the Institute.

The first article, “Consumer-Driven Health Care: Some Questions, Caution, and an Inconvenient Truth” by Professor Arnold Rosoff, provides a substantive introduction to the topic of consumer-driven health care. He begins with a “definition” of the concept of consumer-driven health care and an elaboration on the historical context from which the consumer-driven movement has emerged.\textsuperscript{17}

\textsuperscript{15} Id. at A9-A10.
\textsuperscript{16} The Health Policy Institute was cosponsored by Southern Illinois Healthcare, the Center for Health Law and Policy at the Southern Illinois University School of Law, the Department of Medical Humanities at the Southern Illinois University School of Medicine, and the Paul Simon Public Policy Institute. The Health Policy Institute was supported in part by a grant from Southern Illinois Healthcare.
Professor Rosoff offers his insights and perspective on how various parties, including consumers, employers, insurers, providers, and government regulators, might respond and adapt to the consumer-driven health care phenomenon.\(^{18}\) In doing so, he identifies areas of critical concern. For example, he notes that, at the heart of a successful consumer-driven system is a well-informed, value-conscious consumer. As he goes on to observe, consumers will have to look to health care providers to make available to them timely, useful, accurate, and accessible information about their health care services.\(^{19}\) Mechanisms will need to be put in place to facilitate this. Who will put these mechanisms in place and how this will occur, while critically important questions, are not yet clear.

Professor Rosoff closes his piece with some thoughts and concerns about the consumer-driven health care movement. He expresses some concern, for example, that employers will simply use the consumer-driven model and its defined contribution dimension as a means to force employees to shoulder more of the burden of rising health benefit costs.\(^{20}\) He also voices his apprehension that the evolution of an individualized, consumer-centered financing system for health care will undermine the community risk pooling features of our traditional system, features that offer some protections to the poor and to those who may make mistaken choices regarding health care.\(^{21}\)

The second article in the symposium is “Applying the ‘Do No Harm’ Principle to Health Policy” by Dr. John C. Goodman of the National Institute for Policy Analysis.\(^{22}\) In his article, Dr. Goodman offers readers a brief laying out the foundational policy perspective to support a consumer-driven model for financing health care. He does so first by identifying five critical choices people must make regarding how they finance their health care needs. He then isolates specific public policies currently in place that, in his view, interfere with these critical choices. The choices to be made, Dr. Goodman tells us, are: whether to insure; whether to utilize private or public insurance; whether to seek insurance coverage individually or as part of a group; whether to self-insure or use a third party; and, finally, whether to be a “risk taker” and seek some form of financial protection for the costs of care only after becoming sick.

For each of these choices, Dr. Goodman looks at how current policies impact and, at times, skew the individual’s decision in particular ways, resulting in “socially undesirable decisions.”\(^{23}\) He then suggests a neutral policy that he says would avoid creating the problems found in current policy. For

\(^{18}\) Id. at 21-30.
\(^{19}\) Id. at 22-26.
\(^{20}\) Id. at 33.
\(^{21}\) Id. at 34-35.
\(^{22}\) John C. Goodman, Applying the “Do No Harm” Principle to Health Policy, 28 J. LEGAL MED. 37 (2007).
\(^{23}\) Id. at 37.
example, present policy clearly favors a consumer’s choice to purchase third-party insurance to finance health care over electing to self-insure. The tax code permits an employer to pay health insurance premiums for an employee without these payments being subject to income or payroll taxes. However, if that same employer puts that money into an account for the employee to use to pay for medical expenses, that deposit is taxable. Although recent changes in the law have made it easier for people, through the use of health savings and similar tax-free accounts, to elect to self-insure for medical expenses, “the restrictions on these accounts are,” Dr. Goodman argues, “too onerous.” A neutral policy “treats third-party insurance and individual self-insurance the same.”

The adoption by the government of neutral policies with respect to the five identified choices, policies consistent with a consumer-driven model, would in Dr. Goodman’s analysis have several beneficial consequences. In particular, neutral policies would: provide an environment conducive to nearly universal coverage; level the playing field between public and private insurance, as well as between individual and group coverage and third-party and self-insurance; and ensure that risk is meaningfully considered in determining how much is paid for insurance.

Following Dr. Goodman’s article is the symposium contribution of Dr. Sara R. Collins of the Commonwealth Fund, “Consumer-Driven Health Care: Why It Won’t Solve What Ails the United States Health System.” As her article’s title makes clear, Dr. Collins is no fan of consumer-driven health care. Her position, stated succinctly, is that the consumer-driven model is a “misguided solution” to the problems confronting our health care system.

She begins with a catalogue of the problems facing the nation’s health care system—increasing health care costs, rising health insurance premiums, the ever-present problem of tens of millions of uninsured individuals, and unsolved issues about quality. She does not see how consumer-driven health care will address and resolve any of these problems. She observes, for example, that Americans are not, in reality, insulated from the costs of their health care by a misguided insurance system. To the contrary, she tells us, we “already pay far more out-of-pocket for [our] health care than citizens do in any other industrialized country.” Asking people to pay more, as a consumer-driven

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24 Id. at 37-40.
25 Id. at 38-39.
26 Id. at 48.
27 Id.
28 Id. at 51-52.
30 Id. at 54.
31 Id. at 53-54.
32 Id. at 58-59, 64-66.
system might, will she fears only cause them to avoid getting health care, even when they really need it, and therefore will result in the deterioration of their health status.

Among the other problems identified by Dr. Collins are low satisfaction among current enrollees with their consumer-driven plans and the fact that the information resources necessary to enable consumers to make informed decisions are, at least at the present, not in place. Dr. Collins also is skeptical that the advent of consumer-driven health care will be the antidote to the problem of the uninsured. “The marginal effect of HSAs on the overall number of uninsured Americans depends on the degree to which uninsured adults realize enough tax savings on out-of-pocket spending to make insurance affordable . . .” Using information from a Commonwealth Fund study, she suggests that “the tax savings associated with HSAs would help cover fewer than one million previously uninsured people—even under [the] most generous assumptions . . .” In reality, she believes, the growth of consumer-driven health plans will fragment group insurance markets and increase the uninsured population.

Rather than a consumer-driven model, Dr. Collins suggests the solution to our current problems will come from different initiatives. First, efforts by government and private payers to develop real incentives for health care providers to furnish high-quality, efficient care and to measure and provide information about quality and efficiency are, in her mind, critical to resolving our current problems. Furthermore, policies that favor the pooling of risk with group coverage and community rating, rather than relying on an individualized health insurance market, should be implemented to reduce the number of Americans without insurance.

Todd Sloane, Assistant Managing Editor of the nation’s leading health business weekly, Modern Healthcare, gives the reader his unique perspective on consumer-driven health care in his article, “Consumer-Driven Health Care: But Nobody Knows the Rules of the Road.” Mr. Sloane bolsters several points made by Dr. Collins in her article with additional examples. As he points out, data from studies demonstrate that, when patients have to pay more for their health care (for example, increased co-payments for drugs), the less likely they are to get care and the poorer are their health outcomes. Similarly, he highlights some of the limitations associated with patients acting

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33 Id. at 54.
34 Id. at 70.
35 Id. at 71.
36 Id. at 73.
37 Id. at 74-76.
39 Id. at 83.
as knowledgeable, cost-conscious consumers in the health care marketplace with an anecdote about his father-in-law’s coronary bypass surgery. All of this leads Mr. Sloane to make this point:

To make consumers ready to drive the health care system, supporters of HSAs need three things to happen. Each is a progressively bigger challenge than the last. First, they need transparency of pricing and quality of care data. Second, they need information systems in the form of electronic medical records to drive the first process. Finally, they then need to educate patients to learn how to interpret the data and deal with physicians as equals.

The last article in this symposium is by Professor Marshall B. Kapp, the Garwin Distinguished Professor of Law and Medicine at the Southern Illinois University Schools of Law and Medicine and Co-Director of the SIU Center for Health Law and Policy. Professor Kapp’s contribution, “Patient Autonomy in the Age of Consumer-Driven Health Care: Informed Consent and Informed Choice” tackles a question that underlies much of the debate about consumer-driven health care, namely, whether consumers can be empowered to make informed choices in the marketplace for medical coverage and care. Professor Kapp observes that, for some critics of consumer-driven health care, a major concern is that most consumers will simply be overwhelmed and incapable of making such choices for themselves. Paradoxically, Professor Kapp notes, many of the critics voicing this concern about consumer-driven health care have been strong supporters of patient autonomy and the doctrine of informed consent in the context of clinical decision-making.

As he suggests, one cannot have it both ways. Either we accept the idea of patients as capable, individual decision makers or we do not. We cannot “pick and choose among different categories of health care choices and then apply the autonomy principle selectively.” Whatever the outcome of our national discussion about the merits of consumer-driven health care and its potential as a “solution” to our health care system’s woes, Professor Kapp tells us it should not be dismissed because of the supposed incompetence of people to make their own choices about how to finance their health care needs.

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40 Id. at 84-85.
41 Id. at 85.
43 Id. at 111.
44 Id.
45 Id. at 93.
46 Id. at 117.
CONCLUSION

As we all well know, “solutions” to American’s health care “crisis” come and go. Whether a consumer-driven health care model will prove to have real staying power and can fundamentally transform how we finance health care, or will end up at the policy margins or on the health policy trash heap, remains to be seen. Whatever the outcome for consumer-driven health care, the 2006 Southern Illinois Healthcare/Southern Illinois University Health Policy Institute and this symposium issue of the *Journal of Legal Medicine* provide a valuable resource for our national conversation on this important topic.