

THE WALL STREET JOURNAL.

Big Issues

Consumer Choice: Can It Cure The Nation's Health-Care Ills?

THE WALL STREET JOURNAL ONLINE

December 13, 2005

This is the last of three online debates looking at some of the biggest issues weighing on American public policy. The U.S. health-care system is the topic of this third installment. Joining the debate are American Enterprise Institute scholar Joseph Antos, who was former assistant director for health and human resources at the Congressional Budget Office, John C. Goodman, founder and president of the National Center for Policy Analysis, and Robert Reischauer, president of the Urban Institute and vice chair of the Medicare Payment Advisory Commission. The debate is moderated by Laurie McGinley, assistant bureau chief at The Wall Street Journal's Washington bureau.

Consumers are increasingly being asked to bear more of the costs and responsibility of their health care, in a growing trend called consumer-driven health care (CDHC).

Congress gave CDHC a big boost two years ago by creating health-savings accounts -- tax-favored accounts in which consumers and employers can make deposits for routine health-care expenses. When the money runs out, the patient spends his or her own money until a high-deductible insurance policy (with deductibles of perhaps \$1,500 for individual policies and \$3,500 for family policies) kicks in to cover big-budget medical bills.

Backers say the arrangement will make patients more cost conscious and judicious in their use of medical service, thus restraining health-cost increases; critics say it will cause patients to defer needed treatment and will be attractive only to younger, healthier workers.

MS. MCGINLEY kicks off the debate: Who is right? Is CDHC the solution -- or part of it - - to rising health-care costs? Do consumers have access to enough information about the cost and quality of providers to make good judgments? Will they put off needed care? What about criticisms that CDHC doesn't get to the problem of the real high-cost items -- hospitalizations and very expensive drugs -- that still will be covered by the high-deductible insurance?

MR. GOODMAN writes: Consumer driven health care is not about shifting *costs* to employees. It is instead about shifting *money* from employers to employees, so that employees can manage their own health-care dollars.

It is true that many employers are shifting costs to their employees by charging higher premiums and raising deductibles and co-payments. These activities by themselves do not constitute

consumer-driven health care. CDHC is all about patient power -- having patients make the often-difficult choices between health care and other uses of money instead of having those choices made by large, impersonal bureaucracies.

More than a decade of experience in South Africa, seven years of experience with the Medical Savings Account pilot program in this country, three and a half years experience with Health Reimbursement Arrangements, and two years experience with Health Savings Accounts has produced no evidence of patients skimping on needed health care.

MR. ANTOS writes: Most people have health insurance that pays for nearly all of the cost of health services, including routine and affordable care. That creates what economists call "moral hazard," which means that consumers purchase more health services than they would if they were fully aware of the true cost. Moreover, health-care providers have little incentive to limit the use of services that may make only a marginal improvement in a patient's condition, knowing that a third party is paying the bill. Moral hazard has contributed to the unsustainably rapid growth of health spending in this country. Consumer driven health care is one approach that could break this health inflationary spiral by making consumers more aware of costs. When people realize they are spending their own money, they are likely to be more interested in how that money is spent.

CDHC puts a premium on information about cost, quality, and effectiveness of care. That information is needed by all thoughtful consumers, not just those who have CDHC. Consumerism is adding to the pressure from employers and Medicare that already exists to produce such information. Electronic patient records and an integrated national health-information system are keys to developing such information. Even with such information, patients will need advice from their physicians about treatment alternatives, lifestyle changes, and other actions that can contribute to better health. Simply imposing an economic incentive to reduce the use of care is not sufficient without taking other steps to improve decision making by consumers and health-care providers.

* * *

MS. MCGINLEY asks: Aren't you assuming that consumers make a habit of seeking unnecessary medical care, if their employer-provided insurance is paying the bills? But do consumers really have the time and inclination to do that?

MR. REISCHAUER writes: One of the major problems facing the nation's health-care system is rapidly rising health-care costs. It is unlikely, however, that consumer-driven health care (CDHC) will prove to be a significant solution to this problem. First and foremost, few Americans are now enrolled in CDHC plans, which usually take the form of high-deductible catastrophic plans supplemented with a health reimbursement arrangement (HRA) or health savings account (HSA), and few are likely to find these options attractive in the future. While these options are relatively new, the latest survey evidence estimates that fewer than 4% of workers are now enrolled in such arrangements and well over half of employers express little interest in offering such plans.

This situation could change if employers continue to be hit with premium costs that rise at double or triple the rate of wage increases. Certainly, employers will continue to increase cost sharing (deductibles and coinsurance/co-pays), but this trend is more likely to reestablish the

cost-sharing burdens that were prevalent several decades ago than to constitute a movement to true CDHC. Whatever the outcome, this trend will shift more of the costs of health care onto the sick, especially those with chronic conditions, larger families, and older workers and reduce the burden on the young, the healthy and singles.

To be both effective and equitable, CDHC requires educated consumers, a sophisticated information infrastructure, and complex mechanisms for subsidizing premiums and determining contributions to individuals' health spending accounts. None of these exists now. While a few consumers use the Internet and other sources to educate themselves on health issues, the vast majority are willing to take the advice of their provider. Accessible information on the quality, price, effectiveness and efficiency of health-care services and providers is developing rapidly, but is no where near the minimum standard assumed by well functioning CDHC. And employers, bound in part by Treasury Department regulations, do not vary deductibles, catastrophic caps or contributions to HSAs and HRAs to workers' family incomes or health status as equitable CDHC would call for.

MR. GOODMAN replies: It is with the chronically ill that we have the greatest opportunity to use Health Savings Accounts to control costs and improve quality.

Bob Reischauer is right about one thing: to take full advantage of this opportunity, employers need to be able to make risk-adjusted deposits to the employees' accounts. But he is way underestimating the potential of the market to respond to this expansion of patient power.

Currently, patients pay only 10 cents out of pocket every time they spend a dollar on physicians' services. Health care is almost as free in the U.S. as it is in Canada or Great Britain. In all three countries, patients are mainly paying for their care with time, not with money. Rationing by waiting has special disadvantages for the chronically ill. By contrast, under a system of price rationing, providers would vigorously compete to solve problems that are too often ignored under the current system.

MR. ANTOS writes: Health insurance pays for most of the dollar cost of care for most people with employer-sponsored insurance, but time is the other major cost of seeking medical services. The time cost is often a greater barrier to treatment than money for working people (but typically less of an issue for nonworking dependents). That often motivates demand for more expensive medical procedures that promise less recovery time when less expensive treatment or even "watchful waiting" (no treatment but continued observation to see if the patient will heal on his own) may do as well. Since the additional cost of high-tech medicine is typically very modest for those with insurance, the rational personal decision is clear even though the full cost of that treatment may be many times the cost of less aggressive intervention. The additional cost is spread among everyone with insurance which drives premiums up, but neither patient nor provider weighs the societal costs and benefits.

If the additional services were highly valuable, this would not be an issue. However, Dr. Jack Wennberg and his colleagues at Dartmouth have shown that more health spending is often associated with worse health outcomes for patients, not better outcomes. Clearly, the financial incentives of third-party payment promote additional treatment that, on the margin, can provide very little value.

* * *

MS. MCGINLEY asks: What about Bob's point that sufficient information doesn't yet exist for consumers to make educated choices about their health care? Doesn't that mean that they're dependent on their own doctor for information? How are consumers supposed to bargain with their doctors for better prices -- or find other doctors who offer better prices and quality -- if the information isn't available?

MR. GOODMAN writes: That patients do not have information about price or quality is a natural and inevitable consequence of rationing by waiting.

Since patients aren't paying prices, they have no reason to care and doctors do not compete for patients through the price system. Doctors also do not compete for patients by making quality adjustments. That is why about 80% of primary care physicians do not maintain computerized patient records, despite the enormous potential of such systems to prevent errors and secure better outcomes.

Price information and quality improvements, by contrast, are quite normal wherever you find price rationing. Minute Clinics (which Wal-Mart plans to take nationwide) and Call-a-Doc services involve very little waiting but demand cash on the barrel. Both types of services keep computer records and order prescriptions electronically. In the market for cosmetic surgery, package prices are normal and price comparisons are easy thanks to the fact that third-party payers have not been in the market for years. It is also worth noting that the real price of cosmetic surgery went down during the 1990s as did the price of lasik surgery for the same reasons.

MR. ANTOS replies: We are years away from the kind of information infrastructure that is needed for an efficient health care system of any kind. At present, it is nearly impossible to find out in advance what a health service will cost or to compare that cost among health plans or providers. It is equally difficult to find consumer-friendly information about treatment alternatives or the success their doctor has had in treating their condition. Suppose, however, that the information gap was filled. Would a consumer-driven system mean that we must all turn into medical experts and aggressive bargainers?

No. In a truly consumer-driven system, people would be able to choose how much personal control they wish to exercise over their health care, but they would also pay the full additional cost of a less-efficient health plan or one that offered more amenities. The market would be shaped by those who are most prepared to change health plans if a new and better option emerged. Perhaps 10% to 20% of empowered consumers could change the direction of the private health system.

* * *

MS. MCGINLEY asks: Some people say that health-savings accounts and consumer-directed health care will restrain costs for smaller items, such as visits to doctors' offices, but not for big-ticket items like hospitalizations and expensive drugs, which would end up being covered by a high-deductible insurance policy. What's your view and why?

MR. GOODMAN writes: Currently, deposits to Health Savings Accounts are relatively small. However, over the course of a work-life, the balance of these accounts will grow quite

large, and HSAs will potentially be a factor in every health-care decision -- even for the most expensive services.

Incidentally, I have long favored the casualty approach to health insurance, which is familiar to most people through home and auto insurance policies. Under this approach, insurance would pay the cost of care at a center of excellence, exhibiting both efficiency and high quality. Patients, however, would be free to apply that sum of money to another provider adding funds if necessary from his HSA.

In this way, the patient retains his role as principal buyer and decision-maker in much the same way that you are buyer and decision-maker when repairing your roof after a hail storm or your car after a collision. The people doing the repair, therefore, function as your agent rather than the agent of a third-party payer, even though insurance is paying most of the bill.

* * *

MS. MCGINLEY asks: So, here's another way to frame this debate: With health costs rising, who should pay more -- the government, employers or the consumer?

Mr. GOODMAN responds: Someone must choose between health care and other uses of money. In the future, those choices will become increasingly difficult. Ask yourself who you would like to make the decision in your own case. The government? Your employer? Or, would you like to make those decisions yourself?

In choosing among the alternatives, remember: no one cares more about you more than you care about you. So if you retain the power to make your own decisions and control the money to pay for those decisions, at the end of the day the system is likely to work better for you than if you cede that money and that power to an impersonal bureaucracy.

MR. ANTOS writes: Directly or indirectly, workers pay for their own health insurance. Benefits are simply one part of compensation, and higher insurance costs mean that wage increases will be lower. Shifting to a high deductible plan does not shift costs to employees as a group, but it does make those costs more apparent.

The \$150 billion-plus tax break for employer-sponsored health insurance also comes largely from workers, who pay higher taxes or receive fewer government services than they otherwise would. Low-income people pay less, high-income people pay more -- but high-income people also enjoy a larger tax benefit.

If we ask employers or the government to pay more for middle-class insurance, that simply means lower wages or higher taxes for employees. That also means, as John Goodman indicates, that more of the decisions about one's health care will be made by someone else. That could result in less choice among health plans and more restrictions on what a person may spend his own money on -- surely a less desirable outcome.

People with low incomes or serious health conditions need special assistance to ensure that they can purchase their own health coverage. That could be done without forcing them into one-size-fits-all government programs. As a matter of sound policy and social justice, we should redirect government subsidies so that they are better focused on those who need that help the most.

Capping the federal tax exclusion for employer-sponsored coverage would be an important step in that direction.

MR. REISCHAUER writes: Widespread adoption of CDHC would almost certainly do a bit to restrain the growth in costs for many services, pharmaceuticals and devices because it would curb demand. But the impact is likely to be small and most evident for lower price items that are billed separately and not components of larger service packages -- a vaccination not dressings used in a major operation. The limitations of this approach to cost control are significant and stem from a number of factors including:

- Many things we buy in health care are pieces of larger packages which are undefined when the decisions are made concerning whether to purchase and where to purchase. For example, when one goes to the doctor because of a particular set of symptoms, the doctor ask a number of questions which leads to a series of recommended tests whose results then determine an appropriate treatment regime. One could select the doctor to visit on the basis of price and quality but that is no guarantee that the package of tests and treatments that resulted would be the lowest cost or highest quality. Professor Uwe Reinhardt of Princeton has suggested that a way around this problem would be to have physicians set and post their prices for all services they provide as a fixed percent of the payment rates in the Medicare fee schedule -- in other words, one doctor would advertise that her costs were 92% of the fee schedule, while another might set prices at 103% of Medicare's rates.
- The costs of the really expensive treatments would be largely unaffected because those needing major interventions are usually in no condition to "shop around" and their incentives to do so may be quite limited because, at the margin, their costs would be picked up by their catastrophic policy.

Reference pricing represents a more sensible approach to curbing cost growth. Under this system, basic insurance would cover (with some modest co-insurance) the cost an efficiently provided service that met acceptable quality standards. If an individual wanted more, better or more amenity rich care, she would have to pay for it out of pocket or from her health account. For example, if the cheapest of the eight therapeutically equivalent lipid lowering drugs cost \$30, anyone wanting one that cost \$50 would have to pay the \$20 difference as well as the co-pay required for the \$30 drug. Of course, such a system requires information about quality, cost-effectiveness and efficiency which is not yet available; but much of the information necessary to make CDHC function is also missing.

MR. GOODMAN responds: Bob's idea of reference pricing is a modest suggestion that would create modest improvements. We need something more radical.

We need to replace rationing by waiting with rationing by price, similar to what we see in every other market. Only then will we get a vibrant, innovative marketplace that keeps cost down and quality up.

MR. ANTOS writes: Bob suggests that we make the content of health care more transparent to the consumer and structure insurance to cover the lowest-priced service that meets minimal quality standards. Consumers would be free to pay more, but they would be guaranteed at least the basic level of treatment. That approach is reasonable (with caveats) as far as it goes, but it does not address the larger cost driver: escalating per-capita use of health services. We need to

just say no to marginally-valuable health services, and incentives in the current insurance system make that very difficult.

Reference pricing is biased against the development of new health services that produce better results at a higher price. Clinical trials, a likely source of information on relative effectiveness of a new service, are narrowly focused and may not reveal the full range of potential health benefits offered by the new health service. Reference pricing allows the consumer to buy yesterday's technology at yesterday's prices (in Mark Pauly's terminology), but it may prevent other consumers from buying today's technology at today's prices.

MR. REISCHAUER writes: With health costs rising, people will be picking up the tab. The question is, which of their several hats would they like to wear when they put their money on the table? When government subsidizes the added costs, taxpayers -- current or future -- pay the bill; when employers absorb the costs, workers ultimately bear the burden in the form of lower wages and non-health compensation; when consumers are asked to pay the increment they do so in the form of higher insurance premiums and increased cost sharing. Of course, the distribution among different types of people -- rich vs. poor, healthy vs. sick and workers vs. non workers -- varies greatly depending upon which hat is worn.

As John Goodman points out, the real issue is who should determine the uses to which the added resources are put. In the past, there has been little focus on this issue because we have allowed collective drift to channel incremental resources. We will have a stronger health care system in the future, if individuals have a louder voice in the decision. But appropriate incentives are needed and safeguards for those with limited incomes and those with significant health problems.

I find Joe's criticism of reference pricing -- it may prevent other consumers from buying today's technology at today's prices -- a bit perplexing. Reference pricing puts no barriers in the way of letting people spend their own money to purchase those new services they conclude are worth the costs. Isn't that a principle behind CDHC?

Of course, with rising living standards I would expect the quality threshold we set would rise each year. When new interventions that are more cost-effective than old treatments are developed, they would be incorporated into the basic coverage. When new interventions that are significantly more effective (but not necessarily more cost-effective) than older treatments are developed, we could debate whether we wanted and could afford the higher quality incorporated into the basic coverage.

Unfortunately, too much of what we pay for now has no or only a very weak evidence base. As a result, more health care is not always better and, at least across geographic areas, is often worse. Notwithstanding the public's desire to bring every promising new development on line immediately, we should demand convincing evidence that new interventions are much more effective than older ones or more cost-effective before we promise to cover them through third party payments.

MR. ANTOS replies: This is an attempt at clarification.

A new service might not emerge in the market if the regulatory barriers posed by reference pricing are too high, even if the service has great potential to improve health outcomes (although at a higher price than existing treatments). I agree with Bob that if the service is available,

people could decide whether it is worth the higher price (assuming good information and consultation with their physician). But a narrowly-focused evaluation of effectiveness could miss some of the benefits, and that lack of complete information would skew consumer/physician decisions. If such a bias was expected by the potential innovator (such as a drug company), that could reduce the willingness of the innovator to risk huge sums of money on development of the product or service.

I agree that the basic standard of care would rise over time, but risky R&D could still be discouraged if the evaluation process is seen as flawed. As Bob said, the situation today is even worse, and most of what we do has little evidence to back it up. Of course, by modern regulatory standards, aspirin would not be on the market today because of its side effects even though it is a true wonder drug. There's clearly a risk of going too far in either direction.

MEET THE PARTICIPANTS



Joseph Antos is the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute, focusing on Medicare reform, the regulation of private health insurance, and challenges facing the uninsured. Mr. Antos was assistant director for health and human resources at the Congressional Budget Office. During the late '80s and early '90s, he was the director of the Office of Research and Demonstrations in the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services). In 1986 and 1987, Mr. Antos was principal deputy assistant secretary for management and budget at the Department of Health and Human Services, and later, deputy chief of staff. He was also a senior staff economist on the President's Council of Economic Advisers from 1985 to 1986, helping shape policies on physician payment and managed care.



John C. Goodman founded the National Center for Policy Analysis in Dallas, Texas in 1983 and has been president since. Widely considered "the father of Medical Savings Accounts," he also founded the National Association for Business Economics' health-care roundtable and currently is its chairman. Dr. Goodman has written several books, including, "Lives at Risk," which analyzes the failure of single-payer national health insurance in countries around the world and "Patient Power: Solving America's Health Care Crisis."



Robert D. Reischauer, a director of the Congressional Budget Office from 1989 to 1995, became president of the Urban Institute, a Washington-based nonpartisan policy research organization, in February 2000. Mr. Reischauer is also vice chair of the Medicare Payment Advisory Commission. He served as the Urban Institute's senior vice president from 1981 to 1986 and was the CBO's assistant director for human resources and its deputy director between 1977 and 1981.

Write to the Online Journal's editors at newseditors@wsj.com