

The Future of Consumer-Directed Health Care

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Over the next decade I believe we are going to see a major transformation of American medicine. It won't be the kind of transformation that is normally discussed at health care conferences and at inside-the-Beltway briefings. Nor will it be the kind of change anticipated by the people who gave us the Affordable Care Act (ObamaCare). Instead, what I envision is a large migration of patients and doctors, and facilities and services out of the third-party payer system.

That means a major increase in concierge doctors, concierge facilities and concierge-type services. More generally, it means the creation of new markets where providers are free to repackage and reprice their services without third-party payer approval; where transparency of price and quality becomes the norm for patients; and where suppliers of services compete for patients on price, quality and amenities.

The single most important cause of this transformation will be the Affordable Care Act (ACA). That is especially ironic in four ways. First, the most important purpose of the act was to bring millions of people into the health insurance system, not to push millions of people (at least partially) out of it. A second purpose of the ACA was to change the way medicine is practiced — using electronic medical records, financial incentives and regulatory powers to goad providers into providing lower cost, higher quality, more transparent care. Yet all of these goals will be achieved more quickly, more completely and more effectively outside the system. A third goal of the ACA was to create a more egalitarian system in which all have access to the same care. Yet the world we are about to enter will be the exact opposite — a two-tiered system in which access to the best doctors and the best facilities will depend very much on your ability to pay. A fourth goal of the ACA was to create universal access to care. Yet our more vulnerable populations — the poor, the disabled and the elderly — are likely to have less access to care under the new reforms than they have today.

To see why this is going to happen, let me summarize the impact of four especially important characteristics of the new law.

Response to the Individual Mandate. In a few short years millions of people will be forced to buy a health plan whose cost is going to grow at twice the rate of growth of their incomes. Barack Obama did not create this problem. The spending path we are on dates back four decades. The new legislation, however, will lock us onto a future path that is as bad or worse. The 32 million newly insured plus most of the rest of the population with more generous insurance will push spending higher than it otherwise would have been. Traditional tools to control costs (e.g., more limited benefits, greater cost sharing, etc.) will be limited.

One of the few tools employers and insurers will have left is to turn to more limited networks. For example, you may end up in a plan that covers only half the doctors in your area. It's possible you will have to pay full cost if you go outside your plan's network. More likely, most services will be subjected to "reference pricing," under which your plan pays 100 percent within network and you pay 100 percent of any extra cost you incur outside of the network.

It is precisely this type of reimbursement mechanism that will lead to the steady exodus of providers from the insurance system and allow an unfettered market to develop outside of it.

Responding to the Perverse Incentives of Health Insurance Exchanges. Since I have explained this many times before, I will make this brief. With community-rated premiums, insurers will try to attract the healthy and avoid the sick. After enrollment, their incentive will be to overprovide to the healthy (to keep the ones they have and attract more just like them) and underprovide to the sick (to encourage their departure from the plan and to discourage enrollment by others). The federal employees plan — often cited as a model — functions like one big human resources department. Imagine getting rid of the employer and opening up the system to everyone in Washington, D.C. (And remember for people who go bare while they're healthy and enroll after they get sick, the fines are going to be small and may be nonexistent.) What you would be left with would be a mess.

Bottom line: the health plans in the exchanges will have severe quality problems — problems people with money (or anyone who's willing to spend money on his care) will want to escape from if a health need arises.

Responding to a Bizarre System of Health Insurance Subsidies. For people with below-average income, the subsidies in the exchanges will be two, three, four or five times greater — depending on circumstances — than the health insurance subsidy at the place of work. Competitive pressures alone will cause these people to gravitate to this exchange — although there are many ways this might be done.

Why is this so important? At the place of work, all these people had an employer who functioned as a protector in the health care system. In the exchange they will seek insurance on their own.

Bottom line: the number of people in the exchanges will be many millions more than what the Congressional Budget Office (CBO) is predicting — creating budget problems and exacerbating the quality problems.

Responding to the Imbalance between Supply and Demand. If the economic studies are correct, 32 million newly insured people will try to double their consumption of medical care. Most of the rest of the population will have increased access to preventive services, without copayments and deductibles. As an illustration of where we are headed, if everyone in America got all of the preventive medicine the Preventive Services Task Force says we should get, the average primary care physician would have to spend more than 7 hours a day delivering services to basically healthy people — leaving little time left over for anyone who is actually sick.

Bottom line: We are going to have a huge increase in demand with no change in supply. Since we primarily pay for care with time rather than money, the time price of care (waiting) will shoot up almost everywhere — at the emergency room, at the primary care facilities and for most specialist services.

Redistribution of Services. Even without the transformation I am predicting, there will be a redistribution of health care services from those who have less to those who have more. Anyone who is in a plan that pays below market will have increased difficulty getting care. These are people in Medicare, Medicaid and possibly (as in Massachusetts) people in subsidized plans sold in the health insurance exchanges.

How the Transformation Will Exacerbate This Problem. Every time a doctor leaves the insurance system to become a concierge doctor, he/she will take only a fraction (say one-fourth or less) of the patients the doctor was previously seeing. That means the doctor/patient ratio for everyone left behind will worsen.

Sadly, as doctors and patients seek better, more timely care, they will make matters worse for all those who stay in the third-party payer system.

What Health Care Will Be Like Outside the Health Insurance System. As we've written before, the average concierge doctor already does most of the things the Commonwealth Fund thinks all doctors should be doing. They use telephones and e-mail, they often have same- or next-day services. They keep medical records electronically. They prescribe electronically. We've also pointed out that when patients pay the marginal cost of their care, there is almost always price competition, which tends to produce quality competition as well.

The new legislation may indeed cause the transformation of medical practice that the ACA seeks to bring about. But it will not occur because of the guidance Washington gives to providers in the third-party payment system. It will occur because of the competitive pressures that everyone will face who escapes from that system and practices outside it. And it won't be available to those who need it most.