

Consumer Directed Healthcare: Except for the Healthy and Wealthy It's Unwise

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Many politicians and business leaders are advocating high deductible health insurance plans linked with health savings accounts—so-called consumer-directed healthcare. These policies penalize the sick, discourage needed care (especially primary and preventive care), and direct tax subsidies towards the wealthiest Americans. They offer little hope of slowing the growth of health care costs and add further bureaucratic costs and complexity to our health care financing system.

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INTRODUCTION

Consumer-directed healthcare (CDHC) is center stage in health policy debates. Many politicians and corporate leaders hope that high deductible health insurance policies will cut costs by coaxing people to think twice before visiting the emergency department (ED), drug store, or MRI suite. The basic idea is that Americans are too well insured; if they spend their own money – so the logic goes – they will spend it more wisely.

Sometimes, after a morning in the clinic during cold season when we are inundated with sniffers seeking antibiotics, we see the attraction of such incentives. But then comes a patient with sniffles and pneumonia, or a diabetic heading toward a foot amputation for want of timely podiatric care and reluctance to endure constant needling, or a woman looking for any excuse to put off the discomfort and embarrassment of a mammogram or pelvic exam, or a middle-aged man who finds the prospect of colonoscopy disquieting. Little of what we do to our patients is pleasant for them, and past studies indicate that patients facing steep out-of-pocket costs skip vital care, not just useless visits.¹

Medical care differs from most consumer goods. So far as we know, there is no biological need for a flat-panel television. True, clothing, food, and shelter are necessities, but neither bad genes nor bad luck compels you to buy the high-priced versions—those purchases are generally driven by comfort, aesthetics, or social norms, not fear for life and limb.

For patients, the luck of the draw usually dictates the care they must buy. Men do not require Pap smears, birth control

pills, obstetrical care, or routine breast exams. Americans of European descent rarely suffer sickle cell disease, or non-Jews Tay Sachs. Diabetes and cancer – which reflect a mix of bad luck and bad choices – do not just bring medical complications; they bring financial ones as well. In addition, CDHC ups the ante, amplifying the financial consequences of both bad luck and unfortunate choices.

PLAYING THE NUMBERS

Consumer-directed healthcare policies offer lower premiums in exchange for higher deductibles—at least \$1,050 per person and \$2,100 per family annually, often as high as \$10,000 annually. In the ideal case, such plans are coupled with health savings accounts (HSAs)—tax-free accounts that can be used to pay for the deductible and for medical services like cosmetic surgery that are entirely excluded from coverage. However, half of CDHC enrollees have nothing in their HSAs.²

Under CDHC, healthy people with very low medical expenses win; they get lower premiums and pay only trivial additional amounts out-of-pocket. However, others lose. The Medical Expenditure Panel Survey (MEPS) – which collects detailed medical spending data on a nationally representative sample of Americans – allows prediction of some likely losers.

Using data from the 2003 MEPS,³ we tabulated the numbers and proportions of insured individuals with various conditions whose health care costs exceeded \$1,050 or \$2,100, as well as the mean and median expenditures for these groups. Precise modeling of CDHC's financial impact is difficult for several reasons: (1) the complexity of the thousands of different CDHC plans now on the market; (2) variability in families' marginal tax rates, which determine the size of the tax subsidy to HSAs (those with higher incomes generally enjoy larger tax subsidies); (3) variations in families' insurance coverage (in some families, husbands, wives, children, and step children have different coverage); and (4) the fact that individuals' coverage may change in the course of a year. However, the Federal Government's thresholds for defining high deductible health plans that qualify for HSA tax exemptions – \$1,050 for an individual and \$2,100 for a family – provide a reasonable estimate of the spending levels likely to delineate winners from losers.

We inflated 2003 spending figures to 2006 dollars using Centers for Medicare and Medicaid Services' projected change in per capita personal health expenditures between 2003 and 2006.⁴ We omitted individuals over 65 from most analyses because most CDHC proposals exclude this group, many of whom have costly illnesses and virtually all of whom are covered by Medicare.

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WINNERS AND LOSER

Ladies, we lose. Not only do we (including one of the authors) suffer the pain of childbirth, but it is also expensive. Additionally, we are more diligent in seeking care for chronic illnesses like diabetes and hypertension. While only one third of insured men under 45 hit \$1,050 each year in medical costs, 55.6% of insured young women reached this figure (Table 1). Similar cost disparities disadvantage insured women between 45 and 65, 74.2% of whom “consume” \$1,050 or more in medical care annually. Overall, insured women’s median health expenditure is \$997 higher than men’s. Even subtracting a few hundred dollars for the cost of mammograms and Pap smears (exempted from the deductible in a few CDHC plans), women are still big losers.

The odds are even worse for sick people. More than 90% of insured diabetics cross the \$1,050 annual spending mark; more than half spend at least \$5,000. Similar figures apply to the millions of people with heart disease, emphysema, arthritis, or a history of stroke. Even hypertension or asthma makes you a very bad bet to stay under \$1,050, or even \$2,100.

Most kids are lucky—they use less than \$500 worth of care each year. However, needing even a single prescription medication changes the odds. Of the 12.1 million insured kids in that category, 58.6% zoomed past \$1,050.

CDHC: A BAD BET

Women, with rare exceptions, do not choose their sex. Yet, CDHC will penalize them, as well as men whose major sin is

chronic illness, and many of us who are turning gray. Moreover, as healthy, low-cost patients flee to CDHC plans, premiums for the sick who remain in non-CDHC coverage will skyrocket. Already in the Federal Employee Health Benefits Program, CDHC plans are segregating young, higher-income men from the costlier female and older workers.⁵ For Wal-Mart’s management, shifting to CDHC plans is an explicit strategy to push sicker, high-cost workers to quit.⁶

Consumer-directed healthcare also seems unfair and unwise on other accounts. It seems unfair because the HSA’s tax breaks selectively reward the wealthiest Americans. A single mother with one child who makes \$16,000 annually would save \$19.60 in income taxes by putting \$2,000 into an HSA.⁷ A similar mom earning \$450,000 would save \$720 in taxes.

It seems unwise because CDHC incentives selectively discourage low-cost primary and preventive care. Even 1 day in the hospital would push a patient past the deductible threshold, eliminating any cost-saving incentives for the small group of sick patients who account for the vast majority of health costs. So who would skimp? Patients without known heart disease trying to decide whether their chest pain warrants an ED visit would skimp; or perhaps a young woman whose abdominal pain may be caused by indigestion, or an ectopic pregnancy; or a young man with mild hypertension.

Consumer-directed healthcare incentives to skimp on these relatively low-cost services are unlikely to constrain overall health spending. The United States already has the world’s highest out-of-pocket spending and the highest health costs. Copayments in Switzerland – a nation near the top of the health spending charts – have not reduced total health expenditures.⁸ In Canada, charging copayments had little

Table 1. Mean and Median per Capita Health Spending and Percentage Spending Less than \$1,050 and \$2,100 Among Insured Americans According to Age, Sex, and Diagnosis, 2006

	N (millions)	Mean per capita annual expenditure	Median per capita annual expenditure	Percent of individuals with annual expenditure <\$1,050	Percent of individuals with annual expenditure <\$2,100
Nonelderly Americans					
Diabetic on insulin or oral agent	5.196	10,760	5,774	8.6	17.0
Receiving therapy for arthritis	9.657	10,277	5,425	7.2	20.1
Diagnosed hypertension	26.867	7,035	3,161	21.7	37.3
Asthma attack in the past year	6.887	5,823	2,478	26.9	45.2
Diagnosis of angina or CHD	2.986	13,520	5,925	6.1	12.7
Child needing prescription medication	12.121	2,673	1,305	41.4	65.4
History of stroke	1.833	14,793	8,487	6.5	13.4
Diagnosis of emphysema	1.050	10,213	4,785	15.1	24.7
Males					
0–18 years	32.184	1,535	452	70.6	83.8
18–44 years	35.165	2,766	463	66.9	80.5
45–64 years	26.728	5,947	1,849	37.6	53.8
>64	14.514	9,943	4,231	18.0	29.2
Females					
0–18 years	30.292	1,356	450	71.8	84.8
18–44 years	39.628	3,363	1,266	44.4	62.8
45–64 years	28.279	5,974	2,871	25.8	41.3
>64 years	19.864	9,320	4,334	14.6	27.7
Males 18–64	61.892	4,140	847	54.2	69.0
Females 18–64	67.907	4,451	1,844	36.7	53.8

impact on costs; doctors less frequently saw the poor (and often sick) patients who could not pay, but their appointment slots were filled by more affluent patients who could.^{9,10} This offset has not been examined in U.S. studies that are the basis for the claim that copayments reduce costs. Higher copayments for medications in Quebec resulted in increased ED visits, hospitalizations, and deaths for the poor and elderly,¹¹ confirming the Rand experiment finding in the United States that copayments increase the risk of dying for the sick poor.¹

Moreover, CDHC and HSAs add new layers of expensive health care bureaucracy. Already, insurers and investment firms are vying for the estimated \$1 billion annually in fees for managing HSAs, and Blue Cross and UnitedHealth have chartered their own banks and announced special health care credit cards¹²—presumably charging hefty interest to patients with empty HSAs. Patients must assiduously document their out-of-pocket payments to assure that coverage kicks in once the deductible is met. For doctors, CDHC means collecting fees directly from patients, many of them unable to pay, a task even costlier than billing insurers.¹³ Moreover, doctors and patients will still have to play by insurers' utilization review and other rules—failure to do so disqualifies bills from counting toward the patient's deductible.

Some propose mitigating CDHC's adverse effects by waiving out-of-pocket costs for some high-value services such as recommended preventive care. This approach would add complexity to our already Byzantine reimbursement system. Accurately linking out-of-pocket cost to clinical value – as they suggest – would require much more than a list of procedures. For instance, the cost effectiveness of a pap smear depends on the details of sexual history. Are we really to report to insurers the number of lifetime male sexual partners for each of our female patients? Additionally, how will insurers tailor financial incentives to get patients to the ED promptly if their undiagnosed chest pain signifies cardiac ischemia, but not if it is heartburn?

Behind the rhetoric of consumer responsiveness and personal responsibility, CDHC sets in motion huge resource transfers. The sick and middle-aged pay more, whereas the young and healthy pay less. Women spend more, whereas men spend less. Workers bear more of the burden, whereas employers bear less. The poor skip vital care while the rich enjoy tax-free tummy tucks. And, as in every health reform in memory, bureaucrats and insurance firms walk off with an ever larger share of health dollars.

Conflicts of Interest: None disclosed.

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