

expenses—continues to progress at a remarkable rate. Opinion leaders in health care estimate that technology, more than any other factor in the year 2010, will have a dramatic effect on health care.<sup>1</sup> Despite dissatisfaction and frustration with the current system, patients recognize that many technology-based medical innovations have been remarkably effective.<sup>2</sup>

Public appreciation of the benefit from medical innovations has been accompanied by a belief that Americans are entitled to immediate and broad access to the most sophisticated health care technologies, regardless of cost. How has this unsustainable belief arisen? The third-party system of payment—the absence of direct payment from patient to doctor for most medical expenses—has shielded Americans from considerations of cost and imparted the illusion that “someone else is paying” for medical care. The forces of supply and demand have become lost amid the sea of governmental regulation and oversight in the third-party payer system. The essential step to remedy this is to change the nature of health care insurance so that *patients make direct payments to their health care providers*.

The United States has the costliest health care system in the world on a per capita basis. The growth of managed care in the 1990s, in an attempt to control rising health care costs, temporarily stabilized insurance premiums as well as national health care expenditures. However, average insurance premiums are once again rising by 10 to 15 percent a year, and health expenditures are predicted to increase by more than 16 percent of the gross domestic product (GDP) by 2007 and to double by 2012.<sup>3</sup> Yet rising expenditures on

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1. “HealthCast 2010: Smaller World, Bigger Expectations,” PricewaterhouseCoopers, November 1999.

2. D. M. Cutler and M. McClellan, “Is Technological Change in Medicine Worth It?” *Health Affairs* 11 (September/October 2001): 29.

3. K. Davis and B. Cooper, “American Health Care: Why So Costly?” June 11, 2003, Invited Testimony, Senate Appropriations Committee, Subcommittee on Labor, Health, and Human Services, Education and Related Agencies, Hearing on Health Care Access and Affordability: Cost Containment Strategies.

health care are not confined to the United States. On the contrary, Organization for Economic Cooperation and Development (OECD) data have shown that the universal trend in developed nations is for medical care costs to increase.<sup>4</sup> It is notable that health care markets in the rest of the world are more government-controlled than in the United States.

Thanks to advances in medical care and sanitation, pharmaceutical breakthroughs, and lifestyle changes—all contributing to better health and declining birth rates—the population is aging (see figure 1.1).<sup>5</sup> Since elderly patients are responsible for a large fraction of medical care costs, we seem to be headed for an unaffordable system.

Why worry about high health care costs? After all, few expenditures are more important to society. Moreover, as medical innovation continues, there may be unavoidable costs associated with their use, particularly on their first introduction. This is generally a good thing; developing more effective medical care is a major goal of modern society. In the end, more effective medical care may indeed be less costly, for example, medical instead of surgical therapy or minimally invasive treatment resulting in shorter hospital stays. Clearly, as nations become wealthier, their citizens spend more money on health care.<sup>6</sup> Similarly, people spend more on houses, cars, clothes, and so on, as their income increases. The argument that high and rising health care costs are bad for people needs to be considered in context. People are spending more money on cars, houses, and Internet-related technologies—this has not necessarily been a bad thing. Insofar as people get something that they value for the extra money that they spend on medical care, it *adds* to their real income.

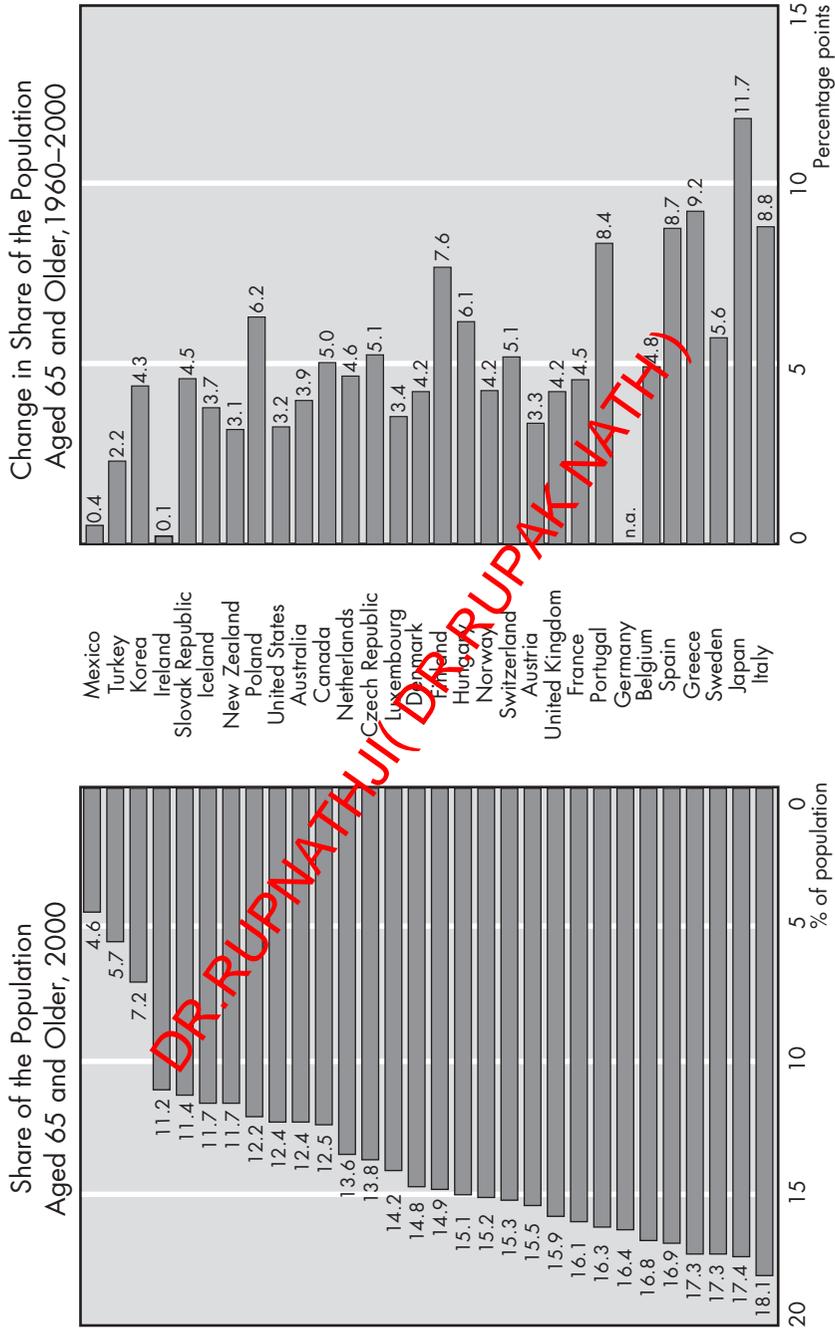
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4. *Health at a Glance: OECD Indicators*, 2003.

5. “World Population Prospects” (1999 revision), United Nations Population Division, Dept. of Economics and Social Affairs, New York 1999.

6. Robert J. Maxwell, *Health and Wealth: An International Study of Health Care Spending*, (Lexington, MA: Lexington Books, 1981); B. Abel-Smith, “Escalation of Healthcare Costs: How Do We Get There?” OECDHealthcare, Paris, 1996.

**Figure 1.1 Share of Population Aged 65 and Older in Selected Developed Countries (2000) and Change in Share (1960–2000)**



Source: Health at a Glance: OECD Indicators, 2003.

Attempts to control costs by limiting services or setting prices misalign incentives and invariably result in supply shortages—this is well documented in history, and the health care industry is no different. At the same time that the United States is leading the world into a new era in medicine with the convergence of molecular biology, medical imaging, and minimally invasive diagnosis and therapy, we have seen an alarming trend toward using technologies that are not state-of-the-art and toward reducing the availability of improved technologies with managed care penetration.<sup>7</sup> These top-down regulatory approaches reduce access to advanced medical technologies and will affect our high standards and expectations of the American health care system.

### How Can We Empower the Patient?

*The critical focus should be on putting consumers in charge of the money and letting them make cost-conscious decisions about spending health care dollars.* During this past presidential primary season, six Democratic presidential candidates have outlined proposals to broaden health insurance coverage. According to a September Commonwealth Fund publication, Democratic plans have estimated costs to the federal budget ranging from \$590 billion to \$6 trillion over a ten-year period.<sup>8</sup> Senator Kerry's plan is estimated to add \$895 billion in cost to the system over ten years.<sup>9</sup> Mr. Kerry's plan also involves shifting the cost from employers and employees to taxpayers by shifting the role of the insurer from the insurance companies to the government. Expanding third-party coverage increases bureauc-

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7. L. Baker and S. W. Atlas, "Diffusion and Utilization of MR Scanners and Managed Care," *Journal of the American College of Radiology* 1 (2004): 478–487.

8. Sara R. Collins, Karen Davis, and Jeanne M. Lambrew, *Health Care Reform Returns to the National Agenda: The 2004 Presidential Candidates' Proposals*, Commonwealth Fund Publication, September 2003.

9. See note 8.

racy and further distances patients from paying for their own medical care. It strengthens the role of the third-party payer. This is the wrong approach. It is time to give the ownership of medical care to the patient and to expose health care to free market competition.

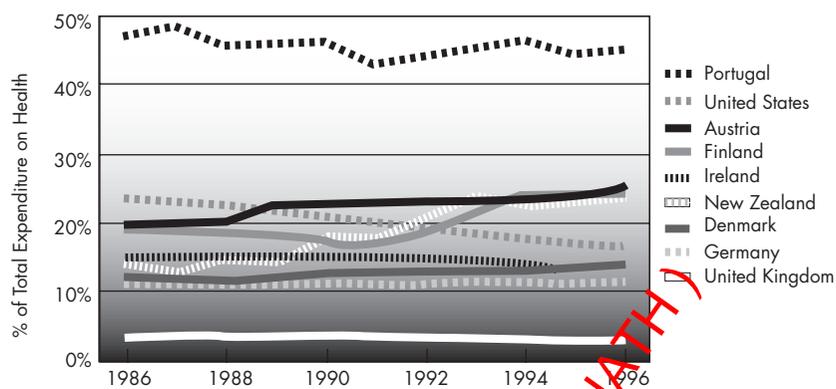
Out-of-pocket expenses for health care are highly important to consumers—the consideration of price is an essential part of a free market economy, and health care is no exception. A number of studies, most notably the “Rand Health Insurance Experiment” conducted from 1974 to 1982, have demonstrated that the more people have to pay for medical care without insurance reimbursement, the less they spend on total medical care. In 1960, more than 55 percent of health care costs were paid directly by the consumers of that care. Currently, third-party payers pay an unprecedented 85 percent of health care costs. This system encourages patients to neglect cost and to overspend for medical care. The separation of the patient from his medical care bills has meant less choice for the consumer: 40 percent of all employers and a full 92 percent of small employers offer only a single choice of health insurance. Yet while many nations seem to be privatizing, the American consumer is increasingly shielded from paying for medical care.<sup>10</sup> Trends show that in the United States, more than in any other country, consumers paid significantly less out-of-pocket in the 1990s (see figure 1.2). This trend of decreasing out-of-pocket expenditures has continued through 2002.<sup>11</sup>

The recently enacted Medicare Prescription Drug Improvement and Modernization Act of 2003 contains two extremely important provisions that have broadened coverage and empowered patients. The Medicare Act defines 1) high-deductible health plans (HDHP) and 2) tax-favored Health Savings Accounts (HSA) to be used in

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10. See note 4.

11. K. Levit et al., *Health Affairs* 23 (2004): 147–159.

**Figure 1.2 Out-of-Pocket Outlays for Health Care**

Source: OECD Health Data 1998.

conjunction with a qualified high-deductible plan. The law has established that HDHPs must have a minimum deductible of \$1,000 for individuals and \$2,000 for families. The main effect has been to reduce the cost of health insurance by changing the role of health insurance to provide coverage for unanticipated and significant expenditures. Health insurance should not cover the small expenses of *routine* medical care. We do not expect our homeowner's insurance to reimburse us when the light bulbs need replacing, or the kitchen sink is clogged, or the gutters and spouts need a yearly cleaning. Likewise, we should not expect health insurance to pay for routine maintenance and minor repairs. This change will accomplish several important goals. Most important, the patient will now pay directly for most medical expenses. By paying directly, the patient will have the responsibility and decision-making authority for how the money is spent. Incentives for value consciousness enter the decision process, since the illusion that "someone else" is paying is eliminated.

Raising deductibles will clearly make health insurance more affordable, for the employer as well as the individual. Lee and Tollen reported that a combination of 30 percent coinsurance with a \$1,000

deductible would reduce premiums by 44 percent.<sup>12</sup> According to that study, savings in health insurance premiums would approach 50 percent by raising deductibles to \$2,000. It is important to note that the cost of health insurance is reduced more by increasing out-of-pocket payments than by paring down insurance benefits. Employers paid \$335 billion in health insurance premiums in 2001, and employer health expenditures have grown from 10 to 15 percent yearly since then. The high cost of health insurance has been the main contributor to the increasing number of uninsured because many employers have withdrawn health insurance from benefits packages. Of those workers who do not have health insurance, about 60 percent work for employers who do not offer this benefit.

High deductibles also will eliminate the bureaucracy and cost that accompany filing small claims. Administrative costs are projected to exceed \$200 billion a year by 2012 and are rising faster than any other health care cost, aside from prescription drugs.<sup>13</sup> Small claims represent a large fraction of the estimated 25 percent of total health care dollars spent on administrative tasks.<sup>14</sup> Eliminating the burden of smaller claims will also markedly reduce the bureaucratic headaches of physicians, patients, and employers alike. Because the patient will pay directly for smaller claims, the patient becomes the customer. Third-party payers will be marginalized for most doctor-patient interactions. Patient and doctor satisfaction will undoubtedly improve because the physician will be caring for the customer

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12. J. S. Lee and L. Tolen, "How Low Can You Go? The Impact of Reduced Benefits and Increased Cost Sharing," *Health Affairs Web Exclusive*, 2002: W229–241.

13. Levit et al., "Trends in U.S. Health Care Spending, 2001," *Health Affairs* (January/February 2003): 154–164; Heffler et al., "Health Spending Projections for 2002–2012," *Health Affairs*, February 7, 2003.

14. S. Woolander, T. Campbell, and D. Himmelstein, "Costs of Health Care Administration in the United States and Canada," *New England Journal of Medicine* 349 (2003): 768–775.

again, restoring the patient-doctor relationship. Satisfaction with the overall system will be improved for everyone.

Paying directly for health services will also diminish the notion of entitlement. As noted earlier, an unprecedented 85 percent of health care costs are paid by third parties—insurance companies, government, or employers. Shielding consumers (patients) from directly paying doctor bills has fostered the idea that patients are entitled to all medical care, regardless of cost. Insurance coverage with near-zero deductibles has implied that health care is “free.” Beyond fostering an unsustainable attitude of entitlement, it has further encouraged elevated demand, since out-of-pocket costs have been minimized. One can see the effect on cost of direct patient payment in the 15 percent of today’s health care marketplace where consumers pay directly for medical care. This 15 percent direct payment part of medical care is mainly encountered at the margins of the system, such as in vision and dental care or cosmetic surgery. Costs have not risen significantly for these because patients are careful about how they spend their own money; that is, when patients pay directly, they are quite successful in holding down cost increases.<sup>15</sup> A number of previous studies, most notably the Rand Health Insurance Experiment conducted from 1974 to 1982, have demonstrated that the more people have to pay for medical care without reimbursement, the less they spend on medical care. This is not a cause for hand wringing, as if patients were making “bad decisions” and foregoing essential medical care; to the contrary, it is simply an illustration of adult consumers making independent decisions that factor in cost. Why should it be any other way?

How would patients pay for their newly uncovered medical care? The Medicare Act of 2003 established a new tax-favored Health Sav-

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15. G. Scanlan, “Increasing Consumer Choice in Health Care: Five Steps Employers Can Take Now,” National Center for Policy Analysis, Brief No. 398, June 17, 2002.

ings Account, or HSA, as the second part of needed change in health insurance. This law allows people to deposit money for health care up to the lesser of the amount of the high deductible of the HDHP, or \$2,600 for individuals or \$5,250 for families. The person who owns the account, as well as others, including the employer, can contribute to the account. Deposits to the accounts would come from the difference in the cost of premiums for a low-deductible insurance policy and for the new one with a high deductible. Regulations are also outlined for the tax-free use of these accounts for qualified medical expenses and in special circumstances for other health insurance.

HSA's are designed to improve on previously established health care savings plans in significant ways. For instance, the laws for the new accounts eliminate many of the 1996 restrictions on medical savings accounts (MSAs) or similar tax-sheltered personal accounts. First, higher caps on contributions are allowed, so high deductibles can be covered. Indeed, the new contribution limits would cover what most patients spend on medical care during any single year (less than \$2,000 according to survey data). A 1989 survey reported by health economists Jensen and Morlock found that nearly three-quarters of patients filed claims for less than \$500 and nearly 90 percent filed claims for less than \$2,000. This means nearly three of four patients would have more than \$2,000 left in savings at the end of the year.

Second, the new HSA's are allowed to accumulate, tax-free, without being subject to "use it or lose it" rules. This distinguishes the new HSA's from employer-offered flexible spending accounts (FSA's), which are forfeited if they remain unused at the end of each year.

Third, HSA's are owned by the individual rather than the employer. Therefore, HSA's are portable, that is, neither tied to a specific employer nor even linked to current employment. Progress toward reducing the number of uninsured from more than 43 million Americans could be made, since many uninsured are those who have

lost jobs, even temporarily.<sup>16</sup> Moreover, a large pool of savings would build during years when medical expenses are relatively low.

Other significant changes should be made to the health insurance industry. For instance, residents of a state are now restricted to the insurance companies in that state for their health insurance. There needs to be a national insurance market. It ought to be possible for an insurance company to be licensed federally and to operate in all states so that the customers in different states can have the benefit of competition and a wider range of alternatives. Deregulation of the insurance industry is essential in promoting competition to benefit consumers.

### **The New Era of Patient Empowerment**

With this purchasing power comes new authority and responsibility, coinciding with the emerging era of self-directed health care. A recent study noted a clear trend toward independent decision making by health care consumers. It found that the percentage of consumers who said they followed their doctor's recommendations without question fell from 53 percent in 2000 to only 36 percent in 2002.<sup>17</sup> In contrast, the percentage of consumers who said they would ask their doctors to send them to the hospital that the patients themselves preferred now stands at 55 percent—up from 36 percent in 2000. Moreover, physicians—at 27 percent—rank only as the second most important source of information for patients, far behind the Internet, with 51 percent of consumers using the Internet to research hospitals, physicians, medical conditions, insurance plans, and other aspects of their own care.

Free market health care will create the appropriate incentives

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16. Robert J. Mills and Shailesh Bhandari, "Health Insurance Coverage in the United States: 2002," U.S. Census Bureau, September 2003.

17. "National Trends in Health Care Consumerism: The Influential Health Care Consumer," Second Annual Report from Solucient, LLC, August 2003.

for discovering efficient ways to capitalize on the vast amount of information now on the Internet for both consumers and insurers. The asymmetry of medical information that has long been an obstacle to consumers is becoming much less important as the information becomes both widely accessible and virtually free. As access to online information about health and health insurance becomes widespread, the arguments against patient-directed health care become tenuous.

### **Can Consumers Make Appropriate Decisions about Health Care?**

Medical test markets that require out-of-pocket purchase have clearly illustrated the effect of the free market and patient decision-making on health care. Recent examples include whole body CT screening, for which prices fell from about \$1,200 to \$300 over a two-year period.<sup>18</sup> In fact, an interesting argument can be made for the societal benefit of the affluent in these settings—that the affluent segment of society serves as the test market for expensive medical innovations not covered by health insurance.

Can consumers make appropriate decisions about health care? The answer is a resounding yes. Arguments to the contrary beg for comparisons to the automobile industry and to self-directed retirement accounts, industries where consumer decision making is now the status quo, despite lengthy discourse on information asymmetry. Moreover, patient empowerment through medical savings accounts will stimulate the demand for more consumer information about health care quality and pricing. These are highly positive changes. The American people should be trusted to make decisions about their own lives. Big brother attitudes do not resonate with indepen-

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18. J. Illes et al., “Self-referred Whole Body Imaging: Current Status and Health Care Implications for the Consumer,” *Radiology* 228 (2003): 346–351.

dent-minded consumers who demand to make their own critical decisions and choices about how and where to spend their money.

### What about the Poor?

Raising deductibles and increasing out-of-pocket payments lead one to question how such a system, where patients pay directly for routine medical expenses up to what will be elevated levels of insurance deductibles, could work for people whose incomes fall short of leaving money for these expenses. Let us not make the mistake, which well-meaning but misguided “experts” continually fall into, of thinking that low-income families would not benefit from paying directly for their health care and choosing where their health care dollars go. There is no greater control than the control of the one who holds the checkbook. The poor are no different from everyone else in the benefits they would derive from lower health care costs, with perhaps one exception—people of low-income now subjected to restrictions on choice from government-based health insurance could enjoy much greater access and choice than their current system allows. So, despite special circumstances based on income, the overall goals and benefits for people regardless of income are at least as positive for low-income families, and potentially even more so.

Many politicians and policymakers espouse the refundable tax credit. These income-based tax credits are “refunded” to people with low income, even when their incomes are below the thresholds for any owed taxes. There is promising data that tax credits will make individual health plans affordable for millions of Americans, the working poor, who do not have access to health insurance through their employers.<sup>19</sup> Of the more than 62,000 health insurance plans sold by eHealthinsurance.com to people in more than forty states,

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19. “The Cost and Benefits of Individual Health Insurance Plans,” eHealthinsurance.com, April 2004.

the average annual premium for an individual was about \$150 a month and about \$288 a month for a family of three. Of the plans purchased, more than three-fourths were Preferred Provider Organization (PPO) plans. Moreover, 94 percent of individual plans and 89 percent of family plans were “comprehensive,” as defined to include inpatient, outpatient, and laboratory and test benefits: more than 75 percent also included prescription drug benefits.<sup>20</sup> Refundable tax credits should be aggressively promoted in conjunction with HDHPs and HSAs, available as of January 2004.

Unemployed individuals and families at or near the poverty level may not have the money to pay for routine health care that is uncovered because of the elevated deductibles. For the unemployed, the practical effect of refundable tax credits leaves much to be desired. Real life dictates that individuals and families need to meet monthly expenses and the often unexpected costs of their health care. Medical expenses do not wait until April 15 to occur. It seems highly unlikely that a once-per-year lump sum generated after tax filing time would prove sufficient for low-income families who otherwise have essentially no extra disposable cash on hand. Voucher systems and programs analogous to food stamps need to be explored, where coupons for medical care are available for very low- and no-income groups. Regardless of the specific system adopted, the goal should be to put the power of the payer directly into the hands of the patient.

## Conclusions

The fundamental driver for increasing medical care spending is third-party payment. The increasing expenditures on bureaucracy, administration, and diagnosis and treatment do not derive from medical technologies but from the method of organization of the medical industry. In a world in which we had direct payment, bu-

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20. See note 19.

reaucracy would be significantly reduced, competition among doctors and insurers would be promoted, many medical developments would be less expensive, and patients would control their health care system.

Clearly, patients must spend directly and consciously for health care; otherwise, considerations of cost will not enter into purchasing. The transaction must occur directly between patient and doctor rather than be shielded from free market effects by the third-party payer system. Let the free market “control” costs, just as it does in other service industries. Cost consciousness is vital to the workings of supply and demand. The structure of health care insurance needs to change to allow value-driven decisions and the control of money by patients. Reducing the restrictions on health savings accounts (including eligibility requirements) and promoting consumer education are areas in which government can play an important role. Improvements in quality and efficiency will also result from the value-driven purchasing of medical care. The U.S. population will welcome these empowering changes. The government just needs to trust the people with their own money.

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