

Virtual Mentor

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Op-Ed

Consumer-Driven Health Care Done Right: Prevention, Evidence-Based Care, and Supportive Patient-Physician Relationships

by Michael D. Parkinson, MD, MPH

The adages *primum non nocere* or “first do no harm” and *caveat emptor* or “buyer beware” apply to the broadly used but often misunderstood term, “consumer-driven health care.”

Consumer-driven health care can be good medicine if it is properly designed, implemented, communicated, and embraced by physicians and health systems as well as by patients. To insure the best possible outcomes, physicians need to understand and lead the consumer-driven health care movement.

This new movement in health care financing creates short- and long-term incentives for preventive care, behavior change, and risk factor reduction. It can also motivate better patient understanding and ownership of acute and chronic care decisions made in partnership with physicians. Models of consumer-driven health care—either the employer-funded health reimbursement arrangements (HRA) or employee- and employer-funded health savings accounts (HSA)—can offer unique opportunities to improve the health of patients, the effectiveness and efficiency of the health care system, and the patient-physician relationship. But it must be done right.

Let's be clear, consumer-driven health care is a major movement and strategy, not merely a benefit design or cost shift. Cost-shifting, in which patients pay more of the direct costs of their health care, is not a necessary feature of consumer-driven health care. Cost-shifting has been used bluntly over the past decade to decrease utilization indiscriminately for effective and ineffective, as well as efficient and inefficient care. Preferred provider organizations (PPOs) and HMOs with higher premiums, higher copayments, and higher deductibles, are increasingly becoming de facto “high deductible health plans.” These plan designs start with a yearly deductible without the benefit of annual employer-funding of HRAs, the potential for accumulation of personally owned funds afforded by HSAs, or the rollover of balances from year-to-year provided by both HRAs and HSAs.

Clinically effective consumer-driven models should respond to the needs of low-, middle- and high-users across the full spectrum of illness. The success of this form of consumer (ie, patient) involvement in treatment and payment decisions depends, in part, on open, candid discussions between patients and their physicians about cost of care.

Physicians must make the effort to be informed about the specifics of their patients' health plans, and they should be able to assess a plan's adequacy using 3 benefit design principles:

Employer funding with 100 percent of first-dollar coverage for evidence-based preventive care. Periodic health examinations, tailored to age- and gender-specific groups and based on authoritative recommendations like those made by the US Preventive Services Task Force, are the cornerstone of consumer-driven care models. Patients should never forgo preventive care that has been proven to prevent disease, disability, and premature death. Behavior change programs for the leading causes of death and preventable medical costs, such as tobacco cessation and weight management, can and should be reimbursed 100 percent under either health reimbursement accounts or IRS-regulated health savings accounts.

"Clinically credible" amounts in the funded account, particularly in the transition year(s) as individuals move from more traditional plan designs. The amount in the account, funded either through the employer contribution to the HRA or in real dollars into the HSA, should allow for the majority of predictable expenses to be covered in the initial years or until rollover of unspent dollars into subsequent years occurs (as it typically does for 60 percent of any full-risk population). Additional dollar incentives can be created to supplement the account for behaviors such as completing a health risk appraisal, participating in a behavior change program, becoming more knowledgeable about one's chronic disease, or receiving evidence-based care. One provider, Lumenos, supplements subscribers' accounts by \$100 for completing a health risk appraisal to better understand and improve health behaviors. Lumenos will add an additional \$100 to the accounts of those with chronic illness who enroll in a personal health coaching program to understand and improve compliance with evidence-based care. Upon demonstration of improved knowledge, skills, and behaviors associated with that condition, patient accounts receive an additional \$200.

A total out-of-pocket maximum that is equal to or less than the typical out-of-pocket expenditure under the previous plan's experience. Under almost any health plans today, those with chronic illness pay more. Clearly they would like to pay less, and most want to get help in better understanding their disease, medications, behavioral improvement options, and medical care options [1, 2]. Many high utilizers may be able to lower their out-of-pocket costs through increased compliance with evidence-based medical advice if they have a better understanding of their medical needs since approximately 30 percent of health care expenditure is wasteful or inefficient. High utilizers and chronically ill patients "solve" for the out-of-pocket maximum exposure when given an option [3].

The vast majority of patients and physicians believe they should discuss both clinical options and the costs of health care choices with each other. Yet, they rarely, if ever, do [4]. The third-party payment system has inadvertently built a wall of silence around cost and value leaving the critical stakeholders—the physician and the patient—with no real opportunity to discuss how cost affects treatment. Consumer-driven models, in which patients are directly responsible for payment, promotes greater information sharing about cost and quality and creates the infrastructure and incentive to do so with greater

ease—and increasingly more accurately. “Counter-detailing”—the exchange of more objective information—about expensive copycat drugs and clinical interventions of marginal benefit becomes a welcome, not a restrictive, clinical interaction, informed but not dictated by financial concerns [5]. Rather than seeking more, the patient will be seeking appropriate care; properly designed consumer-driven plans can help insure adequate resources to get that care.

The future of the patient-physician relationship is brighter under the consumer-driven health care model than in the currently onerous, administratively burdensome, low-trust environment of today’s practice. But all stakeholders in the medical-industrial complex must embrace transparency in quality, cost, and service. As more patients request information from physicians (as they are doing with greater frequency), physician practices must demand complete and accurate information from payors, health plans, consultants, brokers, and other middle men in the health care financing system; payors are beginning to provide these resources to physicians to help them support their patients. Health plans should also assist subscribers and their physicians in encouraging and rewarding clinical, care delivery, and payment innovations that contribute to better outcomes at lower cost. The patients, aware of and spending more of their own money, can and should be on the same “side” as their physicians.

Consumer-driven health care is not a silver bullet for the health care system. But it can be a major driver in realigning incentives, creating personal behavior change, promoting better care management, and encouraging patient-centered innovations in a way that current third-party payment systems cannot.

Many questions about consumer-driven health care remain unanswered. What would really be in the best health and financial interests of patients? Do they know their options and are they willing to pay for them? Can physicians leverage the financial options and consequences of consumer-driven plans to promote better clinical practices [5]? Under the uncomfortable glare of more publicly available information on medical costs, should cost-shifting from the public sector to the private sector continue? Will consumers tolerate different prices charged to public payors (ie, the government) than to private sector employers (ie, themselves) for the same service? Who should pay for graduate medical education if patients choose not to receive care in academically affiliated systems which can do more and charge more, often with no apparent difference in outcome? What will be the impact on the research and development by drug and device manufacturers if their prices become transparent to the actual purchaser of care?

Patients, as always, can and should look to their physicians as trusted professionals and partners. By becoming more knowledgeable about consumer-driven care, by advocating in our communities for “doing it right,” and by embracing the incentives, empowerment, and transparency it creates for our patients, physicians can strengthen the patient-doctor relationship and be true to the profession’s core values of doing no harm and always acting in our patients’ best interests.

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Michael D. Parkinson, MD, MPH, is the chief health and medical officer of Lumenos, a subsidiary of Wellpoint and a leading national provider of consumer-driven health plans. He is also the president-elect of the American College of Preventive Medicine.

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