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CONSUMER-DIRECTED HEALTH CARE AND THE CHRONICALLY ILL

John V. Jacobi*

Insurance plans with consumer-controlled spending accounts are advocated as tools for reducing health costs and empowering consumers. This Article describes their recent development and argues that they are likely to fail. Instead of focusing on the small number of consumers with chronic illnesses who account for the bulk of health spending, they focus on the majority of relatively well consumers. This Article proposes market-based and regulatory changes focused on high-cost patients. To best serve cost and quality goals, health finance responsibility should be divided between consumers and their employers for predictable and routine costs, and government for chronic and catastrophic costs.

Many Americans have given up traditional pension benefits in which they and their fellows contribute to a general pool and receive fixed benefits tied to a common formula. In exchange, they have moved to individual retirement plans, in which they have responsibility and control over funds dedicated to their use. For a decade or more, a similar "ownership society" approach has been urged for health benefits as well—a call that was largely ignored.[1] More recently, health costs are soaring while insurance coverage is shrinking, as managed care's magic has failed the health finance system. As a result, the marketplace has begun to adopt consumer-directed plans, prominently including those combining self-directed individual spending accounts with high-deductible health insurance coverage.[2]

The Medicare Modernization Act of 2003 placed consumer-directed plans squarely within the tax-privileged world of American

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1. *See* JOHN C. GOODMAN & GERALD L. MUSGRAVE, PATIENT POWER: SOLVING AMERICA'S HEALTH CARE CRISIS (1992); Emmett B. Keeler et al., *Can Medical Savings Accounts for the Nonelderly Reduce Health Care Costs?*, 275 JAMA 1666 (1996); Mark V. Pauly & John C. Goodman, *Tax Credits for Health Insurance and Medical Savings Accounts*, HEALTH AFF., Spring 1995, at 125, 126.

2. *See* Anthony T. Lo Sasso et al., *Tales from the New Frontier: Pioneers' Experiences with Consumer-Driven Health Care*, 39 HEALTH SERV. RES. 1071 (2004); Jon R. Gabel et al., *Consumer-Driven Health Plans: Are They More Than Talk Now?*, HEALTH AFF. WEB EXCLUSIVE W395 (Nov. 20, 2002), *at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.395v1 (on file with the University of Michigan Journal of Law Reform).

health coverage.[3] The Florida Legislature has recently mandated that health insurers offering coverage to small employers must offer "a high deductible plan that meets the requirements of a health savings account plan as defined by federal law or a health reimbursement arrangement as authorized by the Internal Revenue Service."[4] And consumer driven care has recently received boosts from Council of Economic Advisors to the President,[5] the Internal Revenue Service,[6] academic commentators,[7] and the popular press.[8]

Will consumer-driven health plans moderate costs and increase access where the managed care revolution and other fixes failed? Researchers have urged that government and employers resist the temptation to jump into consumer-driven health care with both feet until more is known about the effects of such a move.[9] Gov-

3. Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Medicare Modernization Act), Pub. L. No. 108-173, Title XII, 117 Stat. 2066, 2469–80 (2003); *see* H.R. CONF. REP. NO. 108-391, at 836–50 (2003), *reprinted in* 2004 U.S.C.C.A.N. 1808, 2188-200 (describing the creation of a tax-favored HSA-based coverage option); Barry L. Salkin, *Health Savings Account: A New Defined Contribution Health Plan,* 72 PRAC. TAX STRATEGIES 196 (2004) (describing the tax consequences of Title XII of the Medicare Modernization Act).

4. The Affordable Health Care For Floridians Act, 2004 Fla. Sess. Law Serv. 2004-297, § 24 (West).

5. 2004 COUNCIL OF ECONOMIC ADVISORS ANNUAL REPORT 199–200 (supporting Health Savings Account-based plans as means to avoid moral hazard in health insurance).

6. In 2002, prior to the passage of the Medicare Modernization Act, the IRS boosted the prospects of CDHPs by ruling that contributions to Health Reimbursement Arrangements (a precursor to HSAs) could "roll over" from year to year, a step seen as necessary to make CDHPs attractive to consumers. Rev. Rul. 2002-41, 2002-2 C.B. 75; I.R.S. Notice 2002-45, 2002-2 C.B. 93; *see also* Kurt Ritterpusch, *IRS's Health Reimbursement Arrangements Clear Path for "Consumer-Driven" Health Care,* 11 BNA HEALTH L. REP. 979 (2002).

7. *See, e.g.,* CONSUMER-DRIVEN HEALTH CARE: IMPLICATIONS FOR PROVIDERS, PAYERS, AND POLICYMAKERS (Regina Herzlinger ed., 2004) [hereinafter CONSUMER-DRIVEN HEALTH CARE] (gathering commentary in favor of consumer-driven health care).

8. *See* Susan Lee, *A Tax-Code Cure for Ailing Health Care,* WALL ST. J., Aug. 9, 2004, at A13 (identifying traditional third-party health insurance as the "mother of problems" of the American health system and advocating extensive consumer cost responsibility).

9. *See* Gabel et al., *supra* note 2, at W406:

> If there is one message that resonates loudly from our interviews, it is this: "Political partisans, hold your fire! More research and experience are needed!" Independent research is desperately required to address the many issues we have identified. Researchers need to measure the extent of risk selection through studies that examine employees' health status before they enroll in consumer-driven plans and their competitors. Researchers should analyze the redistribution of out-of-pocket costs and services in HRA plans among the sick and healthy. . . . After controlling for risk selection, researchers need to analyze both the consumer-driven plans' ability to control claims expenses and plans' impact on health status and employee satisfaction.

ernments[10] and employers,[11] however, have made the jump, and the movement is likely to accelerate as there are few other viable suggestions emerging in the health reform debate.

This Article will describe the history of serial adoption of incremental and ineffective health care reform measures including, most recently, managed care.[12] It will describe the advancement of consumer-driven care as a natural if controversial response to the failure of managed care. It will also argue that the market has already begun to adopt simple forms of consumer-directed care, ignoring the advice of the movement's more sophisticated advocates in favor of short-term cost-savings. In this regard, consumer-driven care is repeating the mistakes of the managed care "revolution."

The adoption of consumer-driven health plans is likely to fail for two reasons. It will endanger the health and well-being of the chronically ill (those most reliant on health coverage), and it will fail (as did the managed care "revolution") to contain costs. These failures will result in large part from the failure of emerging consumer-driven plans to account for the fact that health spending is severely and necessarily concentrated on care for the very few. Forty percent of health spending is attributable to the sickest 2 percent of the population, and 70 percent to the sickest 10 percent.[13] And health care services used by the chronically ill account for about 75 percent of all direct health care costs.[14] As the lion's

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10. *See* Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, Title XII, 117 Stat. 2066, 2469–80 (2003); The Affordable Health Care For Floridians Act, 2004 Fla. Sess. Law Serv. 2004-297, § 24 (West).

11. *See* Ron Lieber, *New Way to Curb Medical Costs: Make Employees Feel the Sting*, WALL ST. J., June 23, 2004, at A1 (reporting on Whole Foods Market Inc.'s adoption of a consumer-driven plan for its employees comprised of employee spending accounts and high-deductible insurance); Lo Sasso et al., *supra* note 2, at 1073–87 (describing the adoption of consumer-driven plans by several employers).

12. *See* Drew E. Altman & Larry Levitt, *The Sad History of Health Care Cost Containment As Told In One Chart*, HEALTH AFF. WEB EXCLUSIVE W83 (Jan. 23, 2002), *at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.83v1 (on file with the University of Michigan Journal of Law Reform) (documenting the limited impact of an array of cost-containment efforts).

13. *See* Marc L. Berk & Alan C. Monheit, *The Concentration of Health Care Expenditures, Revisited*, HEALTH AFF., Mar.–Apr. 2001, at 9, 12 (updating national health care expenditure studies from 1988 and 1992 based on the results of the 1996 Medical Expenditure Panel Survey (MEPS), a two-year study of 23,000 persons in 10,000 households administered by the Agency for Health Care Research and Quality that gathered information from various sources nationwide, including consumers, health care institutions, and insurance companies). *Id.* at 17 nn.1, 6.

14. Catherine Hoffman et al., *Persons With Chronic Conditions: Their Prevalence and Costs*, 276 JAMA 1473, 1476 (1996); *see also infra* Part III(B) (discussing the costs of care for people with chronic conditions).

share of health expenditures go to those with very predictable, very expensive health care needs, it is at least misleading to suggest, as advocates of consumer-driven care do, that careful shopping can restrain costs for health care as careful shopping can contain costs for clothing[15] or breakfast.[16] The adoption of essentially unregulated, simplistic forms of consumer-driven plans will harm individuals with chronic illness, who simply cannot choose to forego necessary, frequent services, and who face impoverishment and/or denial of care under these plans.[17] It will also harm sponsors and society as a whole, who will discover that the mismatch between consumer-driven plans and the reality of health spending demographics will lead to increased costs.[18] We appear poised to hand over our health finance fate to entrepreneurs who highjack complex and controversial insurance theory, dumb it down, and frustrate our hopes for meaningful reform—much as we did with managed care.

Consumer-driven care seems likely to assume a large portion of the health finance system, and it is likely to appear in the guise of simple plans doomed to failure. As H.L. Mencken said, "There is always an easy solution to every human problem—neat, plausible, and wrong."[19] How can this failure be averted? The final section of this Article suggests market-based and regulatory corrections. As was the case with managed care,[20] plan sponsors may hear the cost-saving message of consumer power (driven home, perhaps, by simplistic analogies to other consumer settings), but miss the subtler

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15. *See* 2004 COUNCIL ECON. ADV. ANN. REP. 195 (likening the moral hazard of third-party health insurance to hypothetical problems of third-party insurance for clothing purchases).

16. *See* CONSUMER-DRIVEN HEALTH CARE, *supra* note 7, at 61–73 (using "breakfast insurance" as a thought experiment to examine moral hazard in health insurance). I do not mean to suggest that Professor Herzlinger is guilty of oversimplification, or that she is not aware of the significant differences between health care and other services. Indeed, the volume she edited contains much that could assist serious regulators of consumer-driven health care. However, the "breakfast insurance" thought experiment obscures as much as it clarifies the serious concerns arising from chronic health care.

17. *See infra* Part III(C)(1).

18. *See infra* Part III(C)(2).

19. H. L. MENCKEN, *The Divine Afflatus*, *in* A MENCKEN CHRESTOMATHY 442, 443 (1949); *see also Consumer-Directed Doctoring: The Doctor Is In, Even If Insurance Is Out: Statement Before The Joint Economic Committee*, 108th Cong. 93 (2004) (statement of Robert A. Berenson) (quoting Mencken).

20. *See* Clark C. Havighurst, *How the Health Care Revolution Fell Short*, LAW & CONTEMP. PROBS., Autumn 2002, at 74–77 (noting that managed care managers failed to employ the tools developed by theoreticians, leading to the social failure of managed care); Alain C. Enthoven & Sara J. Singer, *Unrealistic Expectations Born of Defective Institutions*, 24 J. HEALTH POL., POL'Y & L. 931, 935–36 (explaining how managed care failed to incorporate properly sensible management principles that could have contained costs).

message about the need to thoughtfully tailor consumer-driven health care to the true needs of society, and principally to the needs of the chronically ill. It ends by observing that the prescriptions of the most original advocates for consumer-driven care (those whose complex programs are in danger of being ignored as the marketplace begins to adopt consumer-driven plans) resonate with the recommendations of commentators from other perspectives: embrace the concentration of costs in the chronically ill; ignore the easy "solutions" of the non-problem of health care spending by the well; direct research, resources, and management to the care of the few for whom health insurance is necessary and for whom care is necessarily expensive.

I. THE PATH TO CONSUMER-DRIVEN HEALTH CARE

America continues to search for a way out of its health finance problems. We continue to spend profligately,[21] devoting about half more on health care than other industrialized nations.[22] In return for spending about $1.7 trillion in 2004,[23] we received poor coverage—almost 44 million uninsured for the entire year, and over 81 million uninsured for at least six months.[24] In addition to poor coverage, we are learning that the health care provided is often of poorer quality than we expect from the supposed greatest health care system in the world.[25]

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21. *See* Jon Gabel et al., *Health Benefits in 2003: Premiums Reach Thirteen-Year High As Employers Adopt New Forms of Cost Sharing*, HEALTH AFF., Sept.–Oct. 2003, at 117 (explaining that the cost of health coverage rose 13.9% from spring 2002 to spring 2003, "the largest increase in the cost of job-based insurance since 1990"); Stephen Heffler et al., *Health Spending Projections Through 2013*, HEALTH AFF. WEB EXCLUSIVE W4-79 to W4-80 (Feb. 11, 2004), *at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.79v1 (on file with the University of Michigan Journal of Law Reform) (projecting that though the *rate* of overall health inflation is moderating, increases will continue to exceed the rate of background inflation and national health expenditures will consume 18.4% of GDP by 2013).

22. *See* Manfred Huber & Eva Orosz, *Health Expenditure Trends in OECD Countries, 1990–2001*, 25 HEALTH CARE FIN. REV. 1, 4 (2003) (comparing health expenditures by nation as a percentage of gross domestic product).

23. *See* Heffler et al., *supra* note 21, at W4-80.

24. *See* FAMILIES USA, ONE IN THREE: NON-ELDERLY AMERICANS WITHOUT HEALTH INSURANCE, 2002–2003 1, 3 (2004), *available at* http://www.familiesusa.org/site/DocServer/83million_uninsured_report.pdf?docID=3641 (on file with the University of Michigan Journal of Law Reform); *see also* David Leonhardt, *More Americans Were Uninsured and Poor in 2003, Census Finds*, N.Y. TIMES, Aug. 27, 2004, at A1 (reporting 2003 Census Bureau calculations).

25. *See* Eve A. Kerr et al., *Profiling The Quality of Care In Twelve Communities: Results From The CQI Study*, HEALTH AFF., May–June 2004, at 247, 251–52 ("In the community with the

Our health finance system is a private-market employment-based system with an overlay of public insurance for some of the poor, elderly and disabled. In the face of criticism of this system, Americans reject calls for broadly systemic reforms, tending instead to patch the system with a series of minor fixes and subtle redirections of policy.[26] A series of such shifts over the last several decades has failed to restrain health costs, and have similarly failed to make a dent in the rate of uninsurance.[27] The incumbent fix to American health finance is managed care, by which private firms attempt to reduce costs and thereby expand access by independently reviewing cost decisions made by physicians and patients.[28] This mechanism also has failed to achieve savings over the long term,[29] and we are casting about for the next means by which to control health costs and increase insurance coverage.

A. From Central Planning to Markets—A Shift of Emphasis

The consumer-driven health care movement is a reaction to the dominance of managed care in modern American health insurance. But managed care was itself a reaction to previous cost-

highest overall quality score, less than 60 percent of effective care was delivered on average."); Elizabeth McGlynn et al., *The Quality of Health Care Delivered to Adults in the United States*, 348 NEW ENG. J. MED. 2635, 2641 (2003) (documenting a survey that found the studied population received only 54.9% of recommended care, with the receipt of recommended care similarly poor for preventive, acute, and chronic care); COMMITTEE ON QUALITY OF HEALTH CARE IN AMERICA, INSTITUTE OF MEDICINE, TO ERR IS HUMAN, BUILDING A SAFER HEATH SYSTEM (Linda T. Kohn et al. eds., 2000) (reporting studies that estimate 44,000 to 98,000 Americans die each year as a result of medical errors in hospitals, 7000 from medication errors alone); *see also* THE COMMONWEALTH FUND, FIRST REPORT AND RECOMMENDATIONS OF THE COMMONWEALTH FUND'S INTERNATIONAL WORKING GROUP ON QUALITY INDICATORS: A REPORT TO HEALTH MINISTERS OF AUSTRALIA, CANADA, NEW ZEALAND, THE UNITED KINGDOM, AND THE UNITED STATES (2004), *available at* http://www.cmwf.org/usr_doc/ministers_complete2004report_752.pdf (on file with the University of Michigan Journal of Law Reform) (reporting research that suggests America's higher spending for health care does not translate into better care than that received in nations paying far less for care).

26. Judith Feder, *Crowd-out and the Politics of Health Reform*, 32 J.L. MED. & ETHICS 461, 463 (2004).

27. Altman & Levitt, *supra* note 12, at W83.

28. PETER D. JACOBSON, STRANGERS IN THE NIGHT: LAW AND MEDICINE IN THE MANAGED CARE ERA 8 (2002).

29. *See* Peter D. Jacobson, *Who Killed Managed Care? A Policy Whodunit*, 47 ST. LOUIS U. L.J. 365, 368–69 (2003) (examining the failure of managed care); James C. Robinson, *The End of Managed Care*, 285 JAMA 2622, 2623 (2001) (ascribing the failure of managed care, in part, to its failure to explain how to substitute its judgment for those of physicians and patients).

containment regimes, all of which attempted but failed to create a structural solution to health coverage inflation.[30] Private insurance coverage and federal funding through the Hill-Burton program and the creation of Medicare and Medicaid had fueled health expenditures.[31] In fact, health care spending has been outstripping background inflation for decades, notwithstanding an impressive armamentarium of cost-containment tools.[32] Theories of health finance sought to reduce inflation and increase coverage by balancing governmental and private market power in various ways.[33] As health inflation rose in the 1970s, for example, Congress implemented curbs on Medicare's payment for capital expenditures and instituted peer review of hospital admissions decisions.[34] But the 1970s saw reliance on regulatory solutions featuring supply-side restraints, by which the construction and availability of health care resources were constrained in order to reduce consumption. These controls were guided, in theory, by the community-driven health planning process funded and fostered by the National Health Resources Planning and Development Act of 1974.[35] The principal supply-side cost-containment tool of this health planning process was the certificate of need.[36]

Certificate of need programs attempt to reduce health care costs somewhat indirectly by requiring prior approval for health facilities construction and the initiation of some high-cost health services.[37]

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30. *See* Altman & Levitt, *supra* note 12, at W84 (describing graphically the relatively uniform failure of cost-containment efforts over the last four decades).

31. *See* Randall R. Bovbjerg et al., *U.S. Health Care Coverage and Costs: Historical Development for the 1990s*, 21 J.L. MED. & ETHICS 141, 148–52 (1993); Patrick John McGinley, Comment, *Beyond Health Care Reform: Reconsidering Certificate of Need Laws in a "Managed Competition" System*, 23 FLA. ST. U. L. REV. 141, 145–46 (1995).

32. *See* Bovbjerg et al., *supra* note 31, at 148–52; McGinley, *supra* note 31, at 145–46.

33. *See* M. Gregg Bloche, *The Invention of Health Law*, 91 CAL. L. REV. 247, 253–55 (2003) (discussing the tension between descriptions of health finance as market-driven or socially governed); Rand Rosenblatt, *The Four Ages of Health Law*, 14 HEALTH MATRIX 155, 155–61 (2004) (describing the history of American health law).

34. Social Security Amendments of 1972, Pub. L. No. 92-603, §§ 207, 211(c)(2), 221, 223(b); *see also* Eleanor D. Kinney, *Behind the Veil Where the Action Is: Private Policy Making and American Health Care*, 51 ADMIN. L. REV. 145, 163 (1999).

35. 42 U.S.C. § 300k (repealed 1986); *see also* BARRY R. FURROW ET AL., HEALTH LAW 30–31 (2d ed. 2000); McGinley, *supra* note 31, at 147–48. *See generally* James F. Blumstein & Frank A. Sloan, *Health Planning and Regulation Through Certificate of Need: An Overview*, 1978 UTAH L. REV. 3 (1978); Peter P. Budetti, *Public Policy Issues Surrounding Certificate of Need*, 1978 UTAH L. REV. 39 (1978).

36. Certificate of need programs have other purposes than cost containment, including improving access to care for low-income consumers. *See* Christopher Conover & Frank A. Sloan, *Does Removing Certificate of Need Regulations Lead to a Surge in Health Care Spending?*, 23 J. HEALTH POL., POL'Y & L. 455, 477–78 (1998).

37. *See* FURROW ET AL., *supra* note 35, at 32–35.

Cost savings were to be achieved by reducing the level of investment in new facilities and services. Such constraints responded to the "Roemer effect," which hypothesized that utilization increases directly with the capacity of health facilities—"A bed built is a bed filled is a bed billed"[38]—and therefore focused cost-containment efforts on restricting physical capacity for services.[39] Certificate of need had little or no moderating effect on hospital costs, and probably had little or no effect on other areas of health spending.[40] Whether this failure was attributable to a fault in the theory or to capture of the "community" planning process by the regulated industry,[41] Congress pulled the plug on health planning in 1986 with the repeal of the National Health Resources Planning and Development Act.[42]

By the 1980s, confidence in government cost control through facilities management had begun to give way to confidence in markets, leading to the managed care "revolution."[43] In general, both the theory and practice of the managed care revolution are of interest in evaluating consumer-driven health care and in particular, the divergence between managed care's theory and execution

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38. *Id.* at 29 (citing Milton Roemer, *Bed Supply and Hospital Utilization: A Natural Experiment*, 35 HOSP. 37 (1961)).

39. *See* FEDERAL TRADE COMMISSION & DEPARTMENT OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION: A REPORT BY THE FEDERAL TRADE COMMISSION AND THE DEPARTMENT OF JUSTICE (July 2004), *available at* http://www.ftc.gov/reports/index.htm (on file with the University of Michigan Journal of Law Reform) [hereinafter IMPROVING HEALTH CARE: A DOSE OF COMPETITION] (reporting commentators' view that demand in health care is generated partially by providers); FURROW ET AL., *supra* note 35, at 29; McGinley, *supra* note 31, at 155–56.

40. *See* IMPROVING HEALTH CARE: A DOSE OF COMPETITION, *supra* note 39 (gathering testimony and studies that find no cost-controlling effect); FURROW ET AL., *supra* note 35, at 30; Conover & Sloan, *supra* note 36, at 463. *But see* James B. Simpson, *Full Circle: The Return of Certificate of Need Regulation of Health Facilities to State Control*, 19 IND. L. REV. 1025, 1079–82 (1986) (noting increases in new construction following repeal of CON laws in some states, and arguing that CON laws held down such costly construction).

41. *See* Clark Havighurst, *The Changing Locus of Decision Making in the Health Care Sector*, 11 J. HEALTH POL., POL'Y & L. 697, 709–10 (1986).

42. National Health Resources Planning and Development Act of 1974, 42 U.S.C. § 300k, *repealed by* Pub. L. No. 99-660, §§ 701–816 (1986). *See* FURROW ET AL., *supra* note 35, at 31; CLARK C. HAVIGHURST ET AL., HEATH CARE LAW AND POLICY 714–20 (1998). Many states continue to require certificates of need, however, with varying degrees of community involvement. *See* FURROW ET AL., *supra* note 35, at 32–33 (listing state statutes); McGinley, *supra* note 31, at 144, 160.

43. *See* Pub. L. No. 96-79 (1979) (amending the National Health Resources Planning and Development Act to require health planners to recognize competition as a method of cost control and give special status to HMOs in health planning decisions); FURROW ET AL., *supra* note 35, at 31.

may suggest a cautionary message for consumer-driven health care's future.[44]

B. Proxy Markets: The Rise and Fall of Managed Care

Managed care proposed recentering the focus of health care decision-making in order to contain costs and improve the quality of medical services. Previously, supply-side methods of cost containment such as certificate of need laws assumed excess medical spending and that the cause of excess spending is doctors operating without economic restraint,[45] and therefore provided restraints by removing the occasion of sin—facilities in which to spend.[46] Managed care theorists agree that doctors control spending decisions, but instead of depriving them of the opportunity to overspend, the theorists would inject market incentives into the relationship of insurer, physician, and patient. One branch of managed care theory would create market pressure for cost control and quality improvement by restructuring medical practice into integrated, coordinated group practices, compensated prospectively for all appropriate care, thus encouraging physicians to practice without the "piece-work" incentive of overutilization.[47] Another, more overtly demand-side strain would invest consumers with the power to choose from among a wide variety of plans more or less managed, more or less rich, presumably on the basis of the consumers' economic preferences for more or less coverage by higher or lower quality plans.[48] These two strains are arguably

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44. *See* Robert M. Crane & Laura A. Tollen, *Out Of The Frying Pan And Into The Fire?*, HEALTH AFF. WEB EXCLUSIVE W155, W157 (Mar. 20, 2002), *at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.155v1 (on file with the University of Michigan Journal of Law Reform) (warning that placing large cost-sharing burdens on some employees—particularly those with chronic illness—could lead those employees to be "for all intents and purposes, uninsured for large portions of their care").

45. *See* Bloche, *supra* note 33, at 257–61 (2003) (noting that the meaning of the phrase "excess spending in health care" is often undefined or at least obscure). For present purposes, "excess spending" means spending on care that is either not efficacious or offers so little benefit as to be regarded as inappropriate.

46. E. HAAVI MORREIM, HOLDING HEALTH CARE ACCOUNTABLE: LAW AND THE NEW MEDICAL MARKETPLACE 18–19 (2001) (observing that a system of health finance in which the only criterion for coverage of a procedure is whether physicians regard it as medically "necessary" results in an "artesian well of money" for health services).

47. Gail B. Agrawal & Howard R. Veit, *Is the Health Care Revolution Finished?*, 65 LAW & CONTEMP. PROBS. 11, 20–28 (2002).

48. *See* CLARK C. HAVIGHURST, HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM 177–80 (1995) (advocating private contract theory as a basis

bridged by various forms of "managed competition" which argue for robust competition among plans for market share in a market in which consumers have substantial authority, but in which governmental regulation frames the nature of choices consumers can make.[49] If one can generalize, advocates of reform through managed care would combat moral hazard by realigning physicians' financial incentives, and would protect consumers from a perversion of those incentives through some combination of structural regulation of plans and informed consumer choice among plans.

The goals of these plan-based competition models are both containing cost and improving the quality of care.[50] Managed care became the dominant force in health finance, however, not through systemic reforms institutionalizing uniform structures or regulatory checks, but rather by default, as systemic reform efforts petered out.[51] In other words, market-based reform in health finance emerged as a result of market forces, without the structural constraints envisioned by some theorists. As commercial insurance companies' adoption of managed care methods made attractively priced managed care plans widely available, employers, government, and other sponsors responded.[52] For a time, market-based, managed care-oriented health finance seemed to work. Health care cost trends flattened in the mid-1990s.[53] But health inflation

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for health reform as opposed to public regulation). *See also* Agrawal & Veit, *supra* note 47, at 27–28 (describing contractarian theory of managed-care based health reform); Wendy K. Mariner, *Can Consumer-Choice Plans Satisfy Patients? Problems with Theory and Practice in Health Insurance Contracts*, 69 BROOK. L. REV. 485, 488–90 (2004) (discussing contract mechanisms as a regulatory tool in managed care).

49. *See* Agrawal & Veit, *supra* note 47, at 25–27; Alain C. Enthoven, *The History and Principles of Managed Competition*, HEALTH AFF., Supp. 1993, at 24 (reviewing the structure of managed competition in connection with President Clinton's proposal for health reform); Shoshanna Sofaer, *Informing and Protecting Consumers Under Managed Competition*, HEALTH AFF., Supp. 1993, at 76 (discussing required information disclosures to consumers and the use of managed competition by the architects of President Clinton's proposal for health reform).

50. *See, e.g.*, Paul M. Ellwood & George D. Lundberg, *Managed Care: A Work in Progress*, 276 JAMA 1083, 1083 (1996) (explaining that managed care is designed to enhance quality while containing cost); Enthoven, *supra* note 49, at 37 (citing evidence from the performance of managed care plans establishing that managed competition will provide "high-quality, cost-effective, organized systems of care"); *see also* Agrawal & Veit, *supra* note 47, at 41 ("The managed care industry promised to control health care spending while improving patient outcomes and consumer satisfaction.").

51. *See* John V. Jacobi, *After Managed Care: Gray Boxes, Tiers and Consumerism*, 47 ST. LOUIS U. L.J. 397, 397–98 (2003) (arguing that the ascendancy of managed care constituted piecemeal reform).

52. Agrawal & Veit, *supra* note 47, at 38–39 (explaining that employers turned to managed care as a response to the price increases of more traditional coverage).

53. *See* Cathy A. Cowan et al., *Burden of Health Care Costs: Businesses, Households, and Governments, 1987-2000*, 23 HEALTH CARE FIN. REV. 131, 136–37 (2002) (describing the

again hit double-digit rates in this decade,[54] and shows every sign of continuing well in excess of background inflation for years to come.[55]

Managed care, then, has failed to stabilize American health finance. What lead to the failure—or, as Professor Jacobson has asked, who killed managed care?[56] Commentators have attributed managed care's failure to many causes, including excess litigation, over-regulation, the short-sighted stubbornness of consumers, and the recalcitrance of physicians.[57] But managed care firms themselves clearly bear some of the responsibility for the failure of managed care to bring to fruition its potential offered as an organizing principle in health coverage.[58] If experience with the failure of the managed care revolution is to be instructive in the assessment of consumer-driven health care, it is helpful to assess what caused the theory and practice of managed care to diverge. In theory, managed care promised to serve two functions: cost control and quality improvement.[59] In practice, however, managed care

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reduction in health inflation in 1990s); John K. Inglehart, *Changing Health Insurance Trends*, 347 NEW ENG. J. MED. 956, 957 (2002) ("In the period from 1994 to 1997, as managed-care plans reduced spending, annual increases in premiums and overall health care expenditures were remarkably small . . . .").

54. *See* Gabel et al., *supra* note 21, at 118 (noting that premiums rose 13.9% in 2003, "the third consecutive year of double-digit increases"); Inglehart, *supra* note 53, at 957 (documenting the return of health care expenditure inflation).

55. *See* Stephen Heffler et al., *Health Spending Projections Through 2013*, HEALTH AFF. WEB EXCLUSIVE W4-79, W4-83 to W4-84 (Feb. 11, 2004), *at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.79v1 (on file with the University of Michigan Journal of Law Reform) ("[H]ealth spending will grow at an average annual rate that is 2.1 percentage points faster than economic growth over the projection period [of 2004–2013] and eventually reach 18.4 percent of GDP . . . .").

56. *See* Peter D. Jacobson, *Who Killed Managed Care? A Policy Whodunit*, 47 ST. LOUIS U. L.J. 365, 368–69 (2003).

57. *See* David A. Hyman, *Managed Care at the Millennium: Scenes from a Maul*, 24 J. HEALTH POL., POL'Y & L. 1061, 1068–69 (1999) (blaming unreflective consumer advocates and legislators insufficiently versed in economic theory); Jacobson, *supra* note 56, at 267 (identifying physicians, patients, legislators, the judicial system, the media, health insurers, employers, and hospitals as suspects in the death of managed care); Alain C. Enthoven, *Employment-Based Health Insurance is Failing: Now What?*, HEALTH AFF. WEB EXCLUSIVE W3-237, W3-238 (May 28, 2003), *at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.237v1 (on file with the University of Michigan Journal of Law Reform) ("Managed care has broken down under an onslaught from lawyers, politicians, consumers, and doctors.").

58. *See* Alain C. Enthoven & Sara J. Singer, *Unrealistic Expectations Born of Defective Institutions*, 24 J. HEALTH POL., POL'Y & L. 931, 935–36 (1999) (explaining that managed care plans bear some responsibility for the managed care backlash by "resist[ing] market-improving legislation" and focusing single-mindedly on cost-control); Havighurst, *supra* note 20, at 74–77 (2002) (attributing the failure of managed care in part to the failure of plans to carry through on managed care's theoretical promise of being open with consumers).

59. *See* Agrawal & Veit, *supra* note 47, at 41.

plans responded to a marketplace that valued price,[60] whether because the structure of third-party health coverage created agency problems,[61] because employees lacked appropriate information[62] or the ability to use it,[63] or because members lacked the ability to choose their plan.[64] The imbalance between the cornerstone concerns of quality improvement and cost containment, in favor of the latter, goes a long way in explaining the loss of trust in managed care.[65] This loss of trust caused by over-emphasis on cost containment then caused the consumer backlash that lead to expansion of provider networks, plan withdrawal from utilization review, and other steps that caused managed care plans to raise their premiums.[66] The deviation between health finance theory and practice scuttled the enterprise of reform.

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60. *See* CONSUMER-DRIVEN HEALTH CARE, *supra* note 7, at XXIV (explaining that most managed care plans abandoned the quality improvement goal and focused instead on bargaining with providers to reduce price); Michael H. Bailit, *Perspective: Ominous Signs and Portents: A Purchaser's View of Health Care Market Trends*, HEALTH AFF., Nov.–Dec. 1997, at 85, 86 ("[P]urchasers and consumers seldom buy because of quality of care. Instead, purchasing decisions are based on cost, network size, and administrative convenience. Few purchasers have ever terminated an HMO contract because the quality . . . was poor compared with that of an HMO's competitors."); David M. Frankford, *Regulating Managed Care: Pulling the Tails to Wag the Dogs*, 24 J. HEALTH POL., POL'Y & L. 1191, 1198 (1999) ("[T]he dream of getting plans to compete over quality remains just that, a dream. The dominant form of competition among managed care plans is likely to remain price competition . . . .") (citation omitted).

61. *See* Jacobson, *supra* note 56, at 376–77 (noting the divergence of benefits design interest between employees and employers).

62. *See* Havighurst, *supra* note 20, at 76–77 (noting that managed care plans failed to communicate their methods to members); Jacobi, *supra* note 51, at 401 (noting that managed care plans' control over medical practice was characterized by "reticence, even secrecy").

63. *See* Henry J. Aaron, *A Funny Thing Happened on the Way to Managed Competition*, 27 J. HEALTH POL., POL'Y & L. 31, 31–32 (2002) (suggesting that one failure of the managed care revolution was that consumers behaved with "less than perfect rationality"); Russell Korobkin, *The Efficiency of Managed Care "Patient Protection" Laws: Incomplete Contracts, Bounded Rationality, and Market Failure*, 85 CORNELL L. REV. 1, 48–52 (1999) (describing the limitations of rational choice in health care consumerism).

64. *See* Enthoven, *supra* note 57, at W3-240 to W3-241 (describing the common practice of employers offering their employees a "single source" of coverage); Marc A. Rodwin, *Exit and Voice in American Health Care*, 32 U. MICH J.L. REFORM 1041, 1056 (1999) (arguing that the power of "exit" as a consumer protection device is limited by the lack of choice in plans employers offer their employees).

65. *See* Havighurst, *supra* note 20, at 76–77.

66. *See* Robinson, *supra* note 29, at 2623 (arguing that managed care providers lost "the will to fight against US popular culture and political institutions" and abandoned much of their cost-containing business plans due to the backlash against managed care).

Managed care methods have not been abandoned entirely. The resurgence of cost has led to suggestions of a "managed care rebound" in some markets, as plans have increased utilization review methods, tightened their networks, and otherwise tentatively returned to the basics of managed care. *See* Glen P. Mays et al., *Managed Care Rebound? Recent Changes in*

C. After Managed Care: Cutting Out the Middle Man?

Consumer-driven health care is fundamentally about "getting [health plans] out from between the consumer and the services the consumer wants to consume."[67] To an extent, theory supports the movement to "disintermediated" plans,[68] excoriating managed care for assuming "patient ignorance,"[69] and advancing patient directed plans as means to advance consumer autonomy and contain costs.[70] The move is also supported by the desire of employers to reduce their own financial exposure for increasing health costs by shifting part of the responsibility for costs to their employees.[71] And it is in part merely an evolution of commercial managed care products, and their increased use of varied cost-sharing and product offerings to maintain market share and remain profitable.[72]

One form advocated for consumer-driven health care does not fit this disintermediation mold. To the contrary, it bucks the trend by advocating a complex system in which consumers benefit from a standardization of plans that compete on the basis of quality and

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Health Plans' Cost Containment Strategies, HEALTH AFF. WEB EXCLUSIVE W4-427, W4-429 to W4-433 (Aug. 11, 2004), *at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.427v1 (on file with the University of Michigan Journal of Law Reform).

67. *See* James C. Robinson, *Renewed Emphasis on Consumer Cost Sharing in Health Insurance Benefit Design*, HEALTH AFF. WEB EXCLUSIVE W139, W145 (Mar. 20, 2002), *at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.139v1 (on file with the University of Michigan Journal of Law Reform) ("[H]ealth plans increasingly interpret their role as one of packaging health care services, pricing them at actuarially sustainable rates, gathering and disseminating information, promoting electronic connectivity among all participants, and otherwise getting out from between the consumer and the services the consumer wants to consume.").

68. *See* John V. Jacobi & Nicole Huberfeld, *Quality Control, Enterprise Liability, and Disintermediation in Managed Care*, 29 J.L. MED. & ETHICS 305, 310 (2002) ("[T]he role of the fiscal intermediary between employees and their health providers ... is reduced or eliminated [in the disintermediation movement].").

69. John C. Goodman, *Designing Health Insurance for the Information Age*, *in* CONSUMER-DRIVEN HEALTH CARE: IMPLICATIONS FOR PROVIDERS, PAYERS, AND POLICYMAKERS 224–26 (Regina Herzlinger ed., 2004).

70. *Id.* at 235–39. *See also* Jacobi, *supra* note 51, at 406 ("The promise of most consumer-driven plans is that consumers themselves can act as prudent purchasers if given the chance, obviating the need for managed care plans to act as expert intermediaries between consumers and providers ....").

71. *See* Wendy K. Mariner, *Can Consumer Choice Plans Satisfy Patients? Problems with Theory and Practice in Health Insurance Contracts*, 69 BROOK. L. REV. 485, 504–05 (2004) (describing the cost benefits to employers of various types of new health plans).

72. *See* Inglehart, *supra* note 53, at 958–60 (describing the evolution of health plans to increase cost sharing and use "tiers" of benefits); Gabel et al., *supra* note 2, at W399 to W400 (describing established insurance firms expanding cost sharing and patient choice in measured response to market pressures).

service. Employees are given a choice from among many of these plans, and provided (by the employer) with robust information on the various plans.[73] A key component of this reform is that providers are rewarded in the market for providing efficient, expert care, particularly for high-cost conditions. This reward comes both in terms of the presumed market reward that follows the dispersal of quality information to all consumers,[74] and also from differential, risk-adjusted pricing that directly rewards successful, efficient treatment.[75] If this sounds familiar, it is; advocacy of this form of consumer-driven health care is simply a call to adopt managed competition, the managed care-centered program that Alain Enthoven and other have suggested for over two decades.[76] The merits of a renewed call for managed care-based managed competition is beyond the scope of this paper.[77] The argument in favor of such a plan has, and always has had, a great deal of appeal. However, a managed competition model probably presupposes the continued viability of managed care plans or their close cousins,[78] and substantial governmental oversight.[79] The appeal of this solution to the health finance crisis is substantial, but seems to buck the trend of disintermediation and patient autonomy. As is described below,

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73. *See* Agrawal & Veit, *supra* note 47, at 46–49 (proposing mandates to require employers to offer several managed care plans, other plans, and comparative cost and quality information to employees); Enthoven, *supra* note 57, at W3-243 to W3-245.

74. *See* Michael E. Porter & Elizabeth Olmsted Teisberg, *Redefining Competition in Health Care*, HARV. BUS. REV., June 2004, at 65, 74 (explaining that a condition of "redefined" competition in health care is the availability of information to consumers).

75. *See* Enthoven, *supra* note 57, at W3-243 to W3-246 (arguing that risk adjustment is an integral part of a properly functioning and efficient system, and that technology to accomplish genuine risk adjustment is available but underused).

76. *See* Agrawal & Veit, *supra* note 47, at 25–27.

77. Also beyond the scope of this paper is the variation on the theme of managed competition in which consumers are permitted to mix and match to create their own networks in a do-it-yourself PPO. *See* Mariner, *supra* note 71, at 503–04 (describing programs that permit consumers to "design their own customized health plans"); Gabel et al., *supra* note 2, at W397–99 (describing entrepreneurial start-ups offering do-it-yourself services in conjunction with internet-based information systems on providers). This neither fish nor fowl approach has little market support. It seems unlikely that consumers, already famously reluctant to take the time to review information on health plan quality, will take the time to create their own networks.

78. *See* Agrawal & Veit, *supra* note 47, at 45–49 (describing a "back to the future" proposal featuring managed care plans); Enthoven, *supra* note 57, at W3-243 to W3-244.

79. *See* Agrawal & Veit, *supra* note 47, at 48 (proposing federal requirements for the disclosure of quality data to consumers); Porter & Teisberg, *supra* note 74, at 74–75 (advocating federally mandated uniform benefits floors and universal coverage); Enthoven, *supra* note 57, at W3-247 ("Congress could enact strong incentives for employers to create and join multiemployer, multicarrier exchanges. . . . Congress could create a regulatory body to be sure that exchanges actually promote competition and expand the competitive market.").

however, some melding of consumer direction and case management of high-cost cases may be the brightest hope for the future.[80] The plan envisioned by Agrawal and Veit does not yet have a presence in the market.

Most forms of consumer-driven health care are milder or stronger attempts to avoid reliance on expert intermediaries, and emphasize reliance on consumers themselves to achieve the cost, quality, and access goals of health finance.[81] The spectrum of consumer-driven arrangements, aside from those discussed above that encourage consumers to exercise informed choice in their health plan selection, runs from the mild attempt, in which consumers are given tiered pricing incentives to internalize some of the marginal costs of expensive providers, to the stronger attempt, in which consumers are given the power and responsibility of choosing their care and their provider, at least for a portion of the services they receive.

Consumer-driven plan cost containment rests in general on the observation, supported by common sense and robust empirical evidence, that raising the amount of health costs directly borne by consumers will reduce consumers' consumption of health care services.[82] The simplest way for health plans to couple this basic cost-containment device with a means for consumers to exercise greater autonomy in health care choices is to key member cost-sharing to the price of the service; for example, a physician charging the plan a high price could be accessed only with a high co-payment, while a lower-priced physician (to the plan) could be seen with a lower co-payment.[83] This use of tiers permits members to choose from a broad range of providers, but forces them to bear a part of the excess cost, thereby presumably damping their enthusiasm for the most expensive providers.

This practice is most common in pharmaceutical benefits, where most plans now separate available drugs into three tiers—generic

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80. *See infra* Part IV.C.

81. *See* Goodman, *supra* note 69, at 235–39 (emphasizing informed consumer choice and direct consumer power to select care); *see also* Jacobi, *supra* note 51, at 406 ("The promise of most consumer-driven plans is that consumers themselves can act as prudent purchasers if given the chance, obviating the need for managed care plans to act as expert intermediaries between consumers and providers . . . .").

82. *See* MARK A. HALL, MAKING MEDICAL SPENDING DECISIONS: THE LAW, ETHICS, AND ECONOMICS OF RATIONING DECISIONS 26 (1997) ("Empirical studies verify that patients subject to increased cost sharing spend dramatically less on health care than those who are fully insured."). *See generally* JOSEPH P. NEWHOUSE & INSURANCE EXPERIMENT GROUP, FREE FOR ALL? LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT (1993) (describing and analyzing the RAND Health Insurance Experiment).

83. *See* Jacobi, *supra* note 51, at 403–04.

drugs, lower-cost name brand drugs, and higher-cost name brand drugs—with co-payments rising from tier to tier.[84] The practice has spread to other services, including physicians and hospitals.[85] This practice serves the plan's interests in extricating itself somewhat from its mediating role, while maintaining some level of incentive for employees to use lower-cost providers:

> An emerging set of health insurance benefit designs seeks to retain some of the advantages of provider coordination while broadening consumer choice. Rather than arm-wrestling with doctors and medical groups under the implicit threat of network exclusion, these insurance products include any willing physician and network organization but pass the differences in fee levels on to the consumers through higher premiums or co-payments. At the extreme, these insurance product designs do not negotiate fees at all, creating a market that permits providers to charge whatever they think their patients are willing to pay and that permits consumers to choose among all providers rather than be limited to a contracted subset. The premium charged to the employer covers most or all of the fees charged by low-cost providers, while the employee pays the full incremental cost of the fees charged by more expensive providers.[86]

The move to pricing tiers allows a half step between more traditional forms of managed care and fuller forms of consumer-driven care. At lower levels of price differentiation between tiers, these plans are nearly indistinguishable from traditional PPOs, which offer greater or lesser coverage for in-plan and out-of-plan providers.[87] At moderate levels of differentiation, consumers may be bearing a substantial share of the marginal costs of higher-priced

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84. *See* Haiden A Huskamp et al., *The Effect of Incentive-Based Formularies on Prescription Drug Utilization and Spending*, 349 NEW ENG. J. MED. 2224, 2225 (2003) ("As of spring 2002, 57 percent of workers in the United States who had drug benefits were enrolled in plans with a three-tier formulary."); Geoffrey F. Joyce et al., *Employer Drug Benefit Plans and Spending on Prescription Drugs*, 288 JAMA 1733, 1734 (2002) (describing the range of co-payment schemes in drug benefit plans).

85. *See* Jacobi, *supra* note 51, at 403; James C. Robinson, *Hospital Tiers in Health Insurance: Balancing Consumer Choice with Financial Incentives*, HEALTH AFF. WEB EXCLUSIVE W3-135, W3-140 to W3-141 (Mar. 19 2003), *at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.135v1 (on file with the University of Michigan Journal of Law Reform); Robinson, *supra* note 67, at W147 to W148.

86. Robinson, *supra* note 67, at W147 to W148.

87. *See* Mays et al., *supra* note 66, at W4-432 to W4-433 (discussing how many tiered networks offer very small savings and place very few providers in the highest-cost tier).

providers. At very high levels of price differentiation, members may perceive the plan's "coverage" of high-tier providers to be illusory.

But even the aggressive use of tiers fails to address some central concerns of the consumer-driven health care movement. To the extent plans screen out some providers before creating tiers, they still mediate between consumers and their choice of health care at some autonomy cost to members. And to the extent the graduated co-payments only signal, rather than pass on, the marginal cost of expensive providers, plans merely use proxies for market costs instead of employing them directly.

The more stark break with traditional health plans comes with the consumer-driven plan that combines a spending account with a high-deductible plan, an option that is much discussed,[88] much supported by recent changes in law,[89] and slowly finding a place in the market.[90] The next section describes how these more paradigmatic consumer-driven plans are constructed.

II. WILL CONSUMER-DRIVEN HEALTH CARE WORK? THE DEBATE

Arguments about consumer-driven health care range between philosophical concerns about the nature of society and markets, the imperatives to treat health care as a social cost and respect individual judgments of market participants, and the predictive and pragmatic merits of various proposals for health finance reform. This section will, first, describe what is likely to be the structure of a typical consumer-driven health plan (CDHP). This description is based on the new requirements of the Medicare Modernization Act,[91] recent guidance from the Internal Revenue Service,[92] and the example of a plan available in 2004 to members of the American

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88. *See generally* CONSUMER-DRIVEN HEALTH CARE, *supra* note 7; Pauly and Goodman, *supra* note 1; Gabel et al., *supra* note 2.

89. *See infra* text accompanying notes 111–14.

90. *See* Jon Christianson et al., *Defined-Contribution Health Insurance Products: Development and Prospects*, HEALTH AFF., Jan.–Feb. 2002, at 49, 50 (describing the high visibility but low market penetration of spending accounts with high deductibles); James C. Robinson, *Reinvention of Health Insurance in the Consumer Era*, 291 JAMA 1880, 1882 (2004) ("The most discussed, if least-purchased, contemporary innovation in benefit design is a product that combines a high-deductible PPO with an employer-financed but employee-managed and tax exempt health savings account . . . .").

91. *See* Medicare Modernization Act, Pub. L. No. 108-173, sec. 1201, 117 Stat. 2066, 2469–79 (2003).

92. *See* Rev. Rul. 2002-41, 2002-2 C.B. 75; I.R.S. Notice 2002-45, 2002-2 C.B. 93.

Postal Workers Union.[93] It also relies on an assumption that cost concerns and a preference for administrative ease will predominate in product design here, as it did with managed care.[94] Second, it will provide a brief overview of the arguments for and against a shift to consumer-driven plans.

The next section then asks how consumer-driven care will affect people with chronic illnesses. This analysis is not proposed merely out of a Rawlsian desire to assess the effects of the policy on the least well-off in society in health access terms.[95] Rather, it is a "quick look" test[96] to evaluate the plausibility of consumer-driven care as a means of achieving certain essential goals of health finance reform: restraining cost inflation, making plausible a reduction in the number of people without health insurance coverage,[97] and serving the first two goals without harming, and perhaps even improving, the quality of care provided. I argue that consumer-driven care presents grave risks to the coverage of people with disabilities. I further argue that this fault goes to the heart of the plausibility of consumer-directed care. The great majority of health care is consumed each year by a small fraction of the sickest Americans. People with chronic illnesses are disproportionately represented in this group of the sickest year-in and year-out. If real consumer-driven care—not the form talked about, but the form that shows up—fails to address the health finance needs of the chronically ill,

93. *See* APWU HEALTH PLAN, FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM 49–74 (2004), *available at* http://www.apwuhp.com/openseason/2004Brochure.pdf (on file with the University of Michigan Journal of Law Reform) [hereinafter APWUHP BROCHURE]. I use the postal worker plan, even though it was designed before the passage of the Medicare Modernization Act, because its details are publicly available, well explained, and largely in conformance with the terms of the Medicare Modernization Act. Its structure is typical of plans emerging in the marketplace. *See* Anthony T. Lo Sasso et al., *Tales From the New Frontier: Pioneers' Experiences with Consumer-Driven Health Care*, 39 HEALTH SERVICES RES. 1071, 1078 (2004) (describing CDHP designs); Stephen T. Parente et al., *Employee Choice of Consumer-Driven Health Insurance in a Multiplan, Multiproduct Setting*, 39 HEALTH SERVICES RES. 1091, 1095 (2004) (describing CDHP plan designs).

94. *See* Bailit, *supra* note 60, at 86.

95. *See* JOHN RAWLS, A THEORY OF JUSTICE 303 (1971) ("All social primary goods—liberty and opportunity, income and wealth, and the bases of self-respect—are to be distributed equally unless an unequal distribution of any or all of these goods is to the advantage of the least favored.").

96. The "quick look" terminology is borrowed from the anti-trust context. *See, e.g.*, Marina Lao, *Comment: The Rule of Reason and Horizontal Restraints Involving Professionals*, 68 Antitrust L.J. 499, 502–03 (2000) (describing the "quick look" test in cases brought under the Sherman Act).

97. No one claims that a move to consumer-direct care directly reduces the number of uninsured persons. It is beyond dispute, however, that reducing the number of uninsured persons depends on, or at a minimum is aided by, a reduction in the rate of inflation of the cost of coverage. *See* Havinghurst, *supra* note 48, at 17–19.

it will, like managed care, end up a failed attempt to use market tools to tame health inflation.

A. The Structure of "True" Consumer-Driven Health Care

The central form of CDHP has three parts—or maybe two parts and a gap.[98] In a very simple incarnation,[99] CDHP provides, first, for payment of an amount into a Health Savings Account (HSA) that the consumer and her dependents may use for payment of health expenses.[100] Second, it provides a deductible that the consumer must pay out of her own funds after exhausting the HSA. Third, it provides insurance that attaches after the consumer has expended the HSA contribution and deductible. The insurance may have co-payments, subject to out-of-pocket limits, as does more traditional insurance.[101] Consumers, then, would have substantial control over and responsibility for their health spending. This, of course, is the raison d'être for CDHPs: to reverse or blunt the effect of moral hazard, the artificial willingness to overspend that may follow from traditional third-party insurance, and that is often described as the basis for high American health care costs.[102]

At one end, the plan provides a tax-favored HSA spending account for the employee from which the employee can purchase health care services.[103] At the other end, the plan provides something resembling a traditional PPO, but with coverage that does not attach until the employee has incurred a large deductible.[104] The plan then ordinarily requires the employee to pay an

98. *See* Jon B. Christianson et al., *Consumer Experiences in a Consumer-Driven Health Plan*, 39 HEALTH SERVICES RES. 1123, 1123–24 (2004) (describing benefit plans with "insurance coverage designed to create a 'gap' between the dollars in the account and the level at which a deductible is reached").

99. *See supra* note 93 and accompanying text.

100. *See* Medicare Modernization Act, Pub. L. No. 108-173, sec. 1201, 117 Stat. 2066, 2469–79 (2003).

101. *E.g.* Medicare Modernization Act, Pub. L. No. 108-173, sec. 1201, § 223(c)(2), 117 Stat. 2066, 2471–72 (2003) (defining high deductible health plan for purposes of the Act).

102. *See, e.g.*, Bloche, *supra* note 33, at 260–66 (describing the use of moral hazard in analyzing health insurance structure). *See generally* Tom Baker, *On the Genealogy of Moral Hazard*, 75 TEX. L. REV. 237 (1996); William M. Sage, *Managed Care's Crimea: Medical Necessity, Therapeutic Benefit and the Goals of Administrative Process in Health Insurance*, 53 DUKE L.J. 597, 606–07 (2003) (discussing managed care mechanisms intended to counter moral hazard).

103. *See* Medicare Modernization Act § 223(a), 117 Stat. at 2469.

104. *E.g.* Medicare Modernization Act § 223(c)(2), 117 Stat. at 2471–72.

additional deductible,[105] although this additional deductible is not required for the savings account to maintain favored tax status.[106] How do these three parts fit together?

1. The Health Savings Account—HSAs are the heart of CDHPs. Through this mechanism, the plans give members a sense of ownership over the funds and encourage them to be careful purchasers of health services.[107] Consumers are encouraged to participate in a genuine market for health care services, making judgments, as with any consumer purchase, as to the utility of spending versus saving "their" money. Several conditions encourage this sense of ownership. A consumer is likely to feel greater ownership of funds, and therefore use greater care in spending them, if his ownership rights do not disappear on an arbitrary date such as the end of the tax year. In 2002, the IRS facilitated the expansion of CDHPs when it ruled that unspent funds in a spending account could roll over from tax year to tax year, thereby maintaining the funds' tax-favored status.[108] The Medicare Modernization Act codified that result in statute.[109] The sense of ownership is also enhanced if the funds not only continue from year to year, but in addition can be converted to other uses if not spent on health care.[110] Prior to the passage of the Medicare Modernization Act, funds in spending accounts could only be used for medical services. The Act, however, permits the funds to be withdrawn after the beneficiary reaches retirement age with no penalty, and is subject to tax only as ordinary income; the spending account, under those circumstances, converts to the functional equivalent of an individual retirement account.[111]

105. *E.g.*, Gabel et al., *supra* note 2, at W396 ("When the account is exhausted, enrollees must typically pay out of pocket until the annual deductible is met, after which the plan becomes a traditional major medical plan.").

106. *See* Medicare Modernization Act § 223(a), 117 Stat. at 2469 (permitting the amount of deduction to equal the amount of contribution to the health savings account).

107. *See* Mark V. Pauly & John C. Goodman, *Tax Credits for Health Insurance and Medical Savings Accounts*, HEALTH AFF., Spring 1995, at 126, 130 (arguing that consumers assigned funds in a medical savings account will be incentivized to use them cost-effectively).

108. *See* Rev. Rul. 2002-41, 2002-2 C.B. 75; I.R.S. Notice 2002-45, 2002-2 C.B. 93.

109. Medicare Modernization Act, Pub. L. No. 108-173, sec. 1201, § 223(a), 117 Stat. 2066, 2471–72 (2003).

110. *See* Pauly & Goodman, *supra* note 107, at 130 (explaining that incentives to overspend on medical care are enhanced if funds in the spending account "can eventually be used for purposes other than medical services").

111. *See* Medicare Modernization Act § 223(a). *See also* Barry Salkin, *Health Savings Account: A New Defined Contribution Health Plan*, 72 PRAC. TAX STRATEGIES 196, 199 (2004) (describing a retirement tax benefit).

This mechanism is aimed at blunting the effect of moral hazard. Employees "own" funds available to cover a portion of health expenditures. When faced with a spending decision, they will tend to balance more carefully the cost of a proposed service against the benefits, as they have a much more direct stake in the expenditure than in a system in which they are wholly or partially covered by third-party insurance. If, as many acerbic critics of current third-party insurance insist, the single greatest cause of health inflation is the absence of a true consumer-driven market for health care, then HSAs are central to changes in health insurance.[112] In a simple package, they address the frustration consumers express about interference with medical judgments, and address plan sponsors' concerns about health cost increases.

In the postal worker plan, the plan deposits $1000 per year in the HSA for a member selecting individual coverage, and $2,000 for members electing family coverage.[113] The medical expenses for which funds can be used are somewhat broadly defined to extend to goods and services not covered under the alternative, traditional plan; for example, the funds can be used for dental service, eyeglasses, and contact lenses.[114] There are, however, limits on spending from the HSA, reflecting the plan sponsor's continued exercise of some level of control over fund utilization; orthodontia and cosmetic dentistry cannot be accessed using HSA funds, for example. In fact, HSA funds may be used only for services covered under the traditional plan and a short list of additional services.[115] Members may use in-network providers when spending these funds (and receive in-network prices), but they are not limited to them.[116]

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112. *See* CONSUMER-DRIVEN HEALTH CARE, *supra* note 7, at 58 (identifying the fact that health care systems are guided by someone other than the consumer as the cause of massive health care expenditures); GOODMAN & MUSGRAVE, *supra* note 1, at 12 ("In most other sectors of our economy, individuals who make decisions realize most of the benefit from good ones and bear most of the cost of bad ones. . . . The market for health care could be organized in a similar way.").

113. APWUHP BROCHURE, *supra* note 93, at 49. The plan refers to the spending account as a Personal Care Account (PCA). *Id.* The disparate terminology might be explained by the fact that the brochure applies to 2004 coverage, and the Medicare Modernization Act was not signed into law until December 8, 2003. Medicare Modernization Act, Pub. L. No. 108-173, 117 Stat. 2066 (2003).

114. APWUHP BROCHURE, *supra* note 93, at 53.

115. *Id.* This is a residual check on members' excess health spending; the Medicare Modernization Act permits HSA funding of any "qualified medical expense" recognized under the tax code. Medicare Modernization Act sec. 1201, § 223(d), 117 Stat. at 2472–73 (2003).

116. APWUHP BROCHURE, *supra* note 93, at 18, 52.

Unused funds roll over to the next year, although here again, the plan reflects a compromise between strong principles of consumer ownership of HSA funds and the sponsor's desire to exercise some level of continuing control over expenditures for cost-containment reasons. The plan limits the accumulation of funds in the HSA to $4000 for individual coverage, and $6000 for family coverage.[117] The amounts that may be accumulated are substantial, encouraging thrift among members. But additional HSA funds take on a "use it or lose it" character once the cap has been reached, flipping the incentive toward spending. In contrast, the Medicare Modernization Act permits HSA funds to roll over without limit, permitting accumulated funds to serve primarily as a source for medical spending, but ultimately as a source of retirement funds.[118] The President's Council of Economic Advisors has singled out this strong consumer ownership provision of the Medicare Modernization Act as a particularly important aspect of the cost-containment value of consumer-driven health care:

> Once [an HSA is] established, this money belongs to the individual and can accumulate over time. The account remains with the individual if he or she changes employers. * * * With less reliance on insurance for routine health expenses, consumers would place a greater value on information about health care options and providers. More prudent use of insurance would also reduce "middle-man" costs involving an insurance company in what could otherwise be a simple transaction between the patient and the caregiver.[119]

HSAs, then, provide a fund, considerably under the control of consumers, from which a broad range of health services may be purchased. The postal worker plan adheres to this vision, but with a couple of compromises by which the plan sponsors assert some continued oversight over member spending. The Medicare Modernization Act permits a purer version of consumer control over the spending account. It is evident that the temptation of plan sponsors to fiddle with the theory in the interest of cost control will be substantial.

2. *The Gap: A Deductible to Reach Insurance Coverage*—The second element of consumer-driven plans is somewhat chimerical, as it is a

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117. APWUHP BROCHURE, *supra* note 93, at 53.

118. Medicare Modernization Act § 223(d).

119. 2004 COUNCIL OF ECONOMIC ADVISORS ANNUAL REPORT, *supra* note 5, at 199–200.

void—a gap in coverage that (sometimes, but not necessarily) exists between the limits of a HSA and the attachment point of the high-deductible health plan. The effect of this additional deductible is additive to that produced by the member's ownership of the HSA funds: it minimizes the distortions attributed to the moral hazard associated with third-party insurance.[120] The arguments for the cost-containing effects of HSAs based on a member's sense of ownership for the funds apply even more directly to an additional deductible, as the out-of-pocket funds are literally owned by the member. A sponsor particularly worried about moral hazard might reasonably be reluctant to construct a plan in which the amount contributed to the HSA equaled the amount of the insurance plan's deductible (although such a plan would meet the criteria set in the Medicare Modernization Act for favorable tax treatment).[121] Members with a balance in a HSA equaling the deductible of their insurance plan may, notwithstanding some contingent full ownership of the funds in the future, simply regard the plan as first-dollar coverage: the HSA funds are to be used until exhausted, at which time PPO coverage attaches.[122]

The postal plan has such a buffer. In their first year of membership, members have an additional deductible of $600 for single coverage and $1200 for family coverage after they have exhausted their spending accounts.[123] The ability of members to roll their unspent HSA balances forward, however, could reduce or eliminate the deductible in subsequent years. If, for example, a member with

120. *See* Pauly & Goodman, *supra* note 107, at 129 (arguing that moral hazard can be combatted by setting up a system in which plan members pay at least some expenses out of pocket).

121. *See* Medicare Modernization Act, Pub. L. No. 108-173, sec. 1201, § 223(a), 117 Stat. 2066, 2469 (2003) (stating that payments into an HSA equaling the deductible of the high deductible health plan are permissible as a tax matter).

122. If a personal spending account is constructed to be truly the consumer's, going with him from job to job and converting to a retirement fund after he reaches the age of 65, then moral hazard is substantially lessened as an inflationary concern. *See* 2004 COUNCIL OF ECONOMIC ADVISORS ANNUAL REPORT, *supra* note 5, at 199–200 ("With such accounts, there is an increased incentive to purchase insurance that only covers events that are truly random and large, and to pay for other expenses using an HSA."). Under this reasoning, adding an additional deductible feels like a belt-and-suspenders move unless it is merely a measure to reduce the cost of coverage by shifting costs to the consumer.

123. APWUHP BROCHURE, *supra* note 93, at 54. The freedom of choice promised by the "ownership" of the HAS is further restricted. Although the spending account can be used for some expenditures not covered by the traditional plan, those expenditures do not count toward the deductible that must be incurred before accessing PPO coverage. *Id.* at 53. For example, if the member spent $500 of her spending account on dental services and out-of-network preventive care, she would have to pay both the $500 and the $600 deductible before being eligible for PPO coverage.

single coverage rolled over $600 of the $1000 in her HSA from year one, she would have a $1600 balance at the beginning of year two, and could reach her deductible of $1600 to gain access to PPO coverage with no out-of-pocket spending.[124] The deductible, then, does not pose a barrier to PPO coverage for members who are able to build up funds in their HSA because they have had few health care needs in previous years. After the first year of coverage, the deductible serves as an additional check on spending (and an additional direct savings of funds for the plan sponsor) only for those members who had reason to use the funds in their HSA in previous years.

3. High Deductible Insurance—Advocates of consumer-driven health care readily acknowledge that there is a place for health insurance in its traditional sense, in which insureds or their sponsors pool funds against the possibility of large, unexpected health costs,[125] even though they object to "insurance" coverage of predictable, routine, and relatively minor expenses.[126] Other than the fact that it has an unusually high deductible, the coverage that attaches at the back end of consumer-driven coverage has few novel issues. There is no reason to think it would not have routine cost-sharing requirements and in- and out-of-network price differentials subject to annual out-of-pocket maximums, as does most traditional health coverage.

The high-deductible coverage at the back end of the postal worker plan is a traditional PPO. It requires co-payments of 15 percent for most covered services accessed in-network with a cost-sharing cap of $4500 per year, and a 40 percent co-payment for most out-of-network services with a cost-sharing cap of $9000 per year.[127] It does provide first-dollar coverage for some preventive

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124. *Id.* at 54.

125. *See* GOODMAN & MUSGRAVE, *supra* note 1, at 44 (advocating high-deductible insurance); Pauly & Goodman, *supra* note 107, at 129 (advocating the coupling of individual spending accounts with catastrophic, high deductible health insurance).

126. *See* CONSUMER-DRIVEN HEALTH CARE, *supra* note 7, at 61–64 (likening low-deductible health insurance to "breakfast insurance" in which one purchases coverage for the cost of breakfast); GOODMAN & MUSGRAVE, *supra* note 1, at 58 (criticizing traditional Medicare for paying for minor expenses that beneficiaries could budget for on a routine basis, while failing to cover truly catastrophic costs such as custodial nursing home care); Phil Graham, *Why We Need Medical Savings Accounts*, 330 NEW ENG. J. MED. 1752, 1752 (1994) (likening low-deductible health coverage to "grocery insurance").

127. APWUHP BROCHURE, *supra* note 93, at 19, 56–60. Funds paid from the member's HSA do not count toward this limit. *Id.* at 19. In addition, actual out-of-pocket expenditures of members using out-of-network providers can be substantially higher than $9000, as the difference between the plan allowance—the fee set by the plan for a service—and the actual fee charged by a provider is not counted toward the cap. *Id.* at 56–60.

care, including a routine preventive office visit, routine immunizations, and some routine diagnostic tests.[128] This compromise with the tenet that insurance should not cover minor, predictable expenses acknowledges the benefit and cost-effectiveness of encouraging plan members to use preventive health services, and is consistent with the definition of a "high deductible health plan" in the Medicare Modernization Act.[129]

B. Overview of Arguments for and Against Consumer-Driven Care

Many of the issues surrounding consumer-driven care were subject to analysis and criticism in the 1990s with the introduction of the Medical Savings Account (MSA). MSAs were advanced as a market-based alternative to traditional insurance before and after the 1993–1994 Clinton health reform debate.[130] The Health Insurance Portability and Accountability Act of 1996 (HIPAA) permitted a limited experiment in tax-advantaged provisions of MSAs.[131] The limited experiment bore little fruit,[132] perhaps because of the uncertain future of the products or because managed care seemed to be holding down health inflation in the late 1990s.[133] There was continuing academic interest in consumer-driven plans, however,[134] and the resumption of health cost inflation in this decade lead to an upsurge in entrepreneurial activity advocating a switch to

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128. *Id.* at 50–51. First-dollar coverage for children applies to more frequent routine office visits. *Id.* at 51 (applying coverage for "six visits in the first year").

129. Medicare Modernization Act, Pub. L. No. 108-173, sec. 1201, § 223(a), 117 Stat. 2066, 2469 (2003) (providing a safe harbor for first-dollar preventive care in high-deductible plans, permitting a plan to be tax advantaged as a "high deductible health plan" even if it has no deductible for some preventive care).

130. *See* GOODMAN & MUSGRAVE, *supra* note 1, at 57–59; Pauly & Goodman, *supra* note 107, at 127.

131. The Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, sec. 301, § 220, 110 Stat. 1936, 2037–53 (1996) (permitting a limited experiment with MSAs).

132. *See* U.S. GOVERNMENT ACCOUNTING OFFICE, MEDICAL SAVINGS ACCOUNTS: RESULTS FROM SURVEYS OF INSURERS, GAO/HEHS-99-34 11 (1998) (noting that sales of MSAs failed to approach the sales limits permitted by HIPAA).

133. *Id.*

134. *See, e.g.*, Michael D. Barr, *Medical Savings Accounts in Singapore: A Critical Inquiry*, 26 J. HEALTH POL., POL'Y & L. 709 (2001); William C. Hsiao, *Behind the Ideology and Theory: What Is the Empirical Evidence for Medical Savings Accounts?*, 26 J. HEALTH POL., POL'Y & L. 733 (2001); Regina Jefferson, *Medical Savings Accounts: Windfalls for the Healthy, Wealthy & Wise*, 48 CATH. U. L. REV. 685 (1999); Greg Scandlen, *MSAs Can Be a Windfall for the Rest of Us Too*, 49 CATH. U. L. REV 679 (1999).

consumer-driven care.[135] The buzz created by commentators and business advocates pushed Congress to resurrect MSAs as HSAs in the Medicare Modernization Act.

It is not the purpose of this Article to review the literature on the theoretical debates over consumer-driven care. Complex economic and philosophical concerns regarding consumer-driven care, however, will be summarized. Three of them particularly are worth a brief discussion before moving on: whether consumers desire to master or are capable of mastering the information and decision-making skills necessary to make their own health coverage and care decisions; whether the introduction of consumer-driven care would splinter the health insurance market, causing harmful disruptions in coverage; and whether American health finance should be properly conceived of as a form of social pooling or of individual protection from catastrophic costs.

The first concern is multifaceted, and addresses the choice issue central to consumer-driven care. Whether consumer choice will "work" depends in part on whether consumers can, and will, choose wisely when given the power to do so. Consumer-driven care advocates argue that consumers are capable of so choosing if given access to high-quality, evaluative information.[136] They also argue that consumers will take the time to become informed and therefore will succeed in better gaining access to the services they desire at a cost below that reflected in mediated systems.[137] This positive argument is fueled by adherence to classical economic market theories; the contrary argument owes more to the strains of behavioral economics that have criticized assumptions of classically rational conduct in the health economy.[138] The resolution of this

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135. *See* Christianson et al., *supra* note 90, at 52–53 (describing the emergence of start-up firms seeking to manage aspects of consumer-driven health care, along with their venture capital backers); Gabel et al., *supra* note 2, at W398 to W399 (detailing firms, including start-ups and established insurers, inventing or re-inventing themselves as consumer-driven health plans).

136. *E.g.* CONSUMER-DRIVEN HEALTH CARE, *supra* note 7, at 14–17. Adequate information is not yet suitably available to consumers. *See* David Lansky, *Providing Information to Consumers*, *in* CONSUMER-DRIVEN HEALTH CARE: IMPLICATIONS FOR PROVIDERS, PAYERS, AND POLICYMAKERS 419 (Regina Herzlinger ed., 2004) ("Consumers and purchasers of health care . . . lack the information that can help them evaluate the health care organizations that achieve better results, use proven medical practices, or best meet patients' expectations."); Gabel et al., *supra* note 2, at W400 to W401 ("[T]he most important type of information—the quality of available providers—is not yet adequate to meet consumer needs").

137. *See* GOODMAN & MUSGRAVE, *supra* note 1, at 32–35 (arguing that shifting to a consumer-driven system will encourage the production of expert evaluative information that will be used by motivated consumers).

138. *See* Thomas Rice, *Can Markets Give Us the Health System We Want?*, 22 J. HEALTH POL., POL'Y & L. 383, 405–11 (1997) (arguing that consumers are often unable to use expert

dispute turns on principles of economics and psychology that are in flux and probe the boundaries of individuals' ability to make rational choices about complex, emotionally-laden health treatments. Evaluation of consumer-driven care from a behavioral economics perspective is critically important. To the extent consumer autonomy is dangerous to patients, and consumers turn away from making difficult coverage and treatment decisions, consumer-driven care loses one of its major pillars of support. On the other hand, as well-informed, adequately supported, and well-motivated consumers are comfortable and sensible in the role as master of their health care, consumer-driven care gains support.

The second concern is that adding consumer-driven care as an option will start a chain of events that could threaten the viability of more traditional forms of coverage. If care centered around HSAs appeals to the well, or those who perceive themselves as well, but not to those with substantial health care needs,[139] negative effects could flow from such separation. The flight of "good" risks from traditional plans could raise the per-employee cost of coverage in such plans for the plan sponsor, leading the sponsor to either drop the coverage or increase its employee cost-sharing.[140] If the "good" risks migrate to the consumer-directed plan, the employer could experience an *increase* in costs, as the segment of the risk pool that uses almost no health care in any year will now be responsible for the cost of the annual payments to HSAs whether they spend any of the funds or not.[141] These dislocations could defeat the cost-containment and quality-enhancing goals of consumer-directed care unless employers take a far-sighted view of their obligations to provide coverage to their employees, a view that has not been broadly evident otherwise.[142] Further study is

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information to make complex health decisions, and often have little interest in acquiring the power to make such decisions).

139. *See* Gabel et al., *supra* note 2, at 403 (discussing survey respondents' concern that younger and healthier employees would gravitate to consumer-driven plans disproportionately). *But see* Peter Siegelman, *Adverse Selection in Insurance Markets: An Exaggerated Threat*, 113 YALE L.J. 1223, 1225 (2004) (arguing that adverse selection is often an overstated problem).

140. *See* Gabel et al., *supra* note 2, at W403.

141. *See id.* at W404. The postal plan anticipates this concern and caps the sponsor's exposure by limiting the amount that well members can accumulate in their spending accounts. APWUHP BROCHURE, *supra* note 93, at 53.

142. *See* CONSUMER-DRIVEN HEALTH CARE, *supra* note 7, at 170–75 (describing a complex risk adjustment mechanism that would reward insurers for providing excellent, cost-effective care to high-risk employees). The substantial and transparent price differences of high-risk employees would tempt employers to violate the Americans with Disabilities Act

necessary to understand the magnitude of this splintering phenomenon and risk-adjustment methods needed to remedy it.

The third concern is whether American health insurance should be a social welfare system in which we pool our funds to protect the least lucky of us from both the risk of being denied needed care and the possibility of becoming impoverished as a result of medical costs,[143] or instead should be a market-based system by which individuals choose rationally the most cost-effective means to gain access to the medical services they desire.[144] As a historical matter, American health insurance was guided by a sense of mutual aid or shared risk.[145] In the second half of the Twentieth Century, tendencies toward social pooling of risks for the general benefit of all clashed with tendencies toward honoring individuals' interests in paying no more in premiums than their health status warranted.[146] The injection of market principles is often advocated as a tactic for cost control, and universal insurance coverage through government subsidy is embraced as consistent with or even necessary to the success of market mechanisms.[147] From this perspective, consumer-driven plans are merely attempting to increase the efficiency and quality of the health system, and do not threaten social solidarity.[148] Others have argued that market-oriented moves in health

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and ERISA by shedding an employee whose benefits costs were thousands of dollars higher than the norm. 29 U.S.C. § 1140 (2000) (ERISA); 42 U.S.C. § 12112 (2000) (ADA).

143. *See* Melissa B. Jacoby et al., *Rethinking The Debates Over Health Care Financing: Evidence From the Bankruptcy Courts*, 76 N.Y.U. L. REV. 375, 377 (2001) ("[M]any families declared bankruptcy in the aftermath of illness or injury . . . [using] bankruptcy as a safety net, or as insurance of last resort, in the financial aftermath of medical problems.").

144. *See* GOODMAN & MUSGRAVE, *supra* note 1, at 29–30 (arguing that an ideal health care system would restore a buyer/seller relationship between patients and medical suppliers and create a financing system in which patients spend their own money).

145. *See* WILLIAM A. GLASER, HEALTH INSURANCE IN PRACTICE: INTERNATIONAL VARIATIONS IN FINANCING, BENEFITS, AND PROBLEMS 14–21 (1991) (explaining how America rejected a national health insurance system but health insurance in its early forms exhibited preference for social solidarity over individualism); John V. Jacobi, *The Ends of Health Insurance*, 30 U.C. DAVIS L. REV. 311, 315–17 (1997) (noting that American health insurance first favored social pooling forms).

146. *See* Jacobi, *supra* note 145, at 318–19 (discussing trends in both individualist and communal directions).

147. *See* Pauly & Goodman, *supra* note 107, at 130–31.

148. *See* GOODMAN & MUSGRAVE, *supra* note 1, at 657 (arguing that injecting market forces into health care delivery will reduce waste and increase consumer satisfaction with services); Mark A. Pauly, *Who Was That Straw Man Anyway? A Comment on Evans and Rice*, 22 J. HEALTH POL., POL'Y & L. 467, 467–69 (1997) (defending a market-oriented economic analysis of health systems as consistent with the social goals of public welfare).

finance harm social solidarity and pit segments of society against each other.[149]

The American health insurance system is a mixed public/private system in which aspects of markets and regulation mix in an ever-changing swirl of activity. When health insurance covers necessary, (relatively) expensive, and unplanned treatments, there are strong claims that American democratic norms require equality of access to this important vehicle of social security.[150] The arguments are more attenuated concerning expenditures that are more likely to be routine, predictable, and (relatively) inexpensive. The line between these two types of coverage is not a clear one,[151] but public policy claims ensuring access to the former are stronger than those for the latter.[152] A political and philosophical analysis of the proper mix of collective and individual responsibility for access to health care and health coverage will continue to guide health reform debate. As consumer-driven plans are likely to appear with increasing frequency in the near future, tentative and contingent judgments as to their merits are necessary and, as is described below, possible.

Reform efforts in our public/private health finance system will benefit from good information on the nature of consumer capabilities in health care and the selection dynamics based on risk and health status. They will be shaped by common understandings of social obligation and individual responsibility. This Article does not pretend to resolve these issues, as it has a narrower purpose. It takes a "quick look" at the prospects for consumer-driven care's success or failure on the basis of the single but vitally important criterion of providing for the chronically ill. Holding aside the

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149. Robert G. Evans, *Going for the Gold: The Redistributive Agenda Behind Market-Based Health Reform*, 22 J. HEALTH POL., POL'Y & L. 427, 457–63 (1997) (arguing that market-based proposals are intentionally or unintentionally a device to redistribute funds away from the poor and sick to the wealthy and well); Gail Shearer, *Commentary—Defined Contribution Health Plans: Attracting the Healthy and Well-Off*, 39 HEALTH SERVICES RES. 1159, 1159 (2004) ("[T]he year 2003 may well go down in health care history as the year that the health care system officially abandoned the premise that the community has a responsibility to care for each member, replacing it with the philosophy that individuals should each look after themselves.").

150. *See* Deborah A. Stone, *Beyond Moral Hazard: Insurance as Moral Opportunity*, 6 CONN. INS. L.J. 11, 43–45 (1999).

151. *See infra* Part II.B (describing the burden of the cost of predictable but expensive and necessary care on people with chronic illness).

152. This Article does not address the dispute over defined benefit versus defined contribution plans. The former describes traditional insurance in which members are provided access to a defined slate of services and subjected to co-payments and deductibles. The latter describes systems in which members have access to a set level of financial support and may use the funds to achieve their health coverage goals. *See* Mariner, *supra* note 71, at 497 (describing defined contribution financing).

larger questions of health care by making a series of reasonable assumptions, it examines the important ways that care for the chronically ill drives health expenditures, and then evaluates the extent to which the adoption of a HSA-anchored model is likely to affect the problems of financing chronic care.

In making these assessments, the history of managed care suggests examining the plans likely to be available in the marketplace. The managed care plans that dominated the 1990s bore little resemblance to the managed care plans of theoretical imagination. While commentators in the 1980s and 1990s debated increasingly interesting and complex issues associated with the theory of managed care, the market adopted stripped-down constructs created to contain cost. Similarly, the plans likely to be available in the near future will bear little relationship to theoretical constructions, but instead will be cost-saving measures shaped by the level of regulation governing their activity. The next section will examine the patient-directed cognate to those HMOs against the needs of the health economy to provide coverage for people with chronic illnesses.

III. WILL CONSUMER-DRIVEN CARE WORK? FOCUS ON THE CHRONICALLY ILL

A. Health Reform Must Account for Chronic Illness

As managed care was working its way to market dominance in the 1990s, it slowly became clear that managed care in practice focused overwhelmingly on cost control, as opposed to its theoretical focus on increasing quality while reducing cost through reorganization. Theorized managed care continued, but as actual managed care developed market share, the scholarly analysis turned to the more practical question of the effect the managed care financing conversion was having on the cost and quality of care. The reviews were mixed—decidedly more so than managed care theory would have lead us to expect.[153] Theorizing about consumer-driven care is

153. *See, e.g.*, Donald M. Berwick, *Payment by Capitation and Quality of Care*, 335 NEW ENG. J. MED. 1227, 1228 (1996) (discussing the effect of managed care payments on health outcomes); Randall S. Brown et al., *Do Health Maintenance Organizations Work for Medicare?*, HEALTH CARE FINANCING REV., Fall 1993, at 7, 8 (1993) (examining the cost effect of Medicare's use of managed care); Robert Miller & Harold S. Luft, *Managed Care Plan Performance Since 1980: A Literature Analysis*, 271 JAMA 1512, 1515 (1994) (examining the quality and cost performance of managed care); Edward Yelin et al., *Health Care Utilization and Outcomes*

in its early stages, but the empirical and practical analysis of consumer-driven care is beginning to happen.[154] Even in advance of substantial evidence, there is reason to be concerned about the fit of consumer-driven health care to its goals in a way that differs significantly from the case of managed care, casting considerable doubt on the value of consumer-driven health care as a health reform vehicle.

What effect would the use of CDHPs by people with chronic illness have on the cost of and access to care? This is a question different from that raised in the previous section, which reviewed some of the literature on broad and complex questions of health economics and policy. This section asks whether using the CDHPs that are likely to be marketed will "work." By "likely to be marketed," I mean those plans that I assume, based on the current (limited) marketplace, legal structures, and lessons drawn from the development of managed care, are likely to be adopted in the near future. By asking whether consumer-driven care will "work," I ask whether it is likely to reduce cost inflation without significantly harming (in health status or financial security) a particular and particularly vulnerable population: the chronically ill. I focus on the chronically ill both because access to health care is obviously very important to them, and because their care accounts for a large proportion of national health costs. The inability of a proposed health financing reform to deal adequately with the problems of chronic illness should be regarded as prima facie evidence that it is not ready for adoption. The basic, cost-driven form of CDHP is likely to fail that test.

B. The Cost of Health Care for the Chronically Ill

Discussions of health finance reform tend to treat health care costs as either homogeneous or randomly distributed.[155] They are neither. If health costs were homogeneously distributed, we wouldn't need health insurance at all. Instead, we would budget

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Among Persons With Rheumatoid Arthritis in Fee-for-Service and Prepaid Group Practice Settings, 276 JAMA 1048, 1050 (1996) (comparing quality data in managed care and fee-for-service settings).

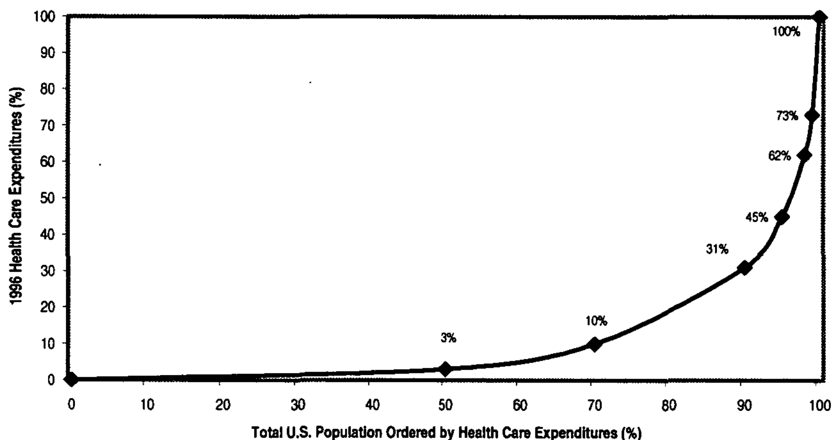
154. *See* Christianson et al., *supra* note 98, at 1123–24; Stephen T. Parente et al., *Evaluation of the Effect of a Consumer-Driven Health Plan on Medical Care Expenditures and Utilization*, 39 HEALTH SERVICES RES. 1189, 1202–06 (2004); Lo Sasso et al., *supra* note 93, at 1079–80.

155. *See* 2004 COUNCIL OF ECONOMIC ADVISORS ANNUAL REPORT, *supra* note 5, at 198–201.

for health costs as we do for other regular, predictable costs such as food and shelter. And if health costs were randomly distributed—that is, if the identity of persons in need of expensive care each year were entirely unpredictable—then everyone would be an equal risk for health insurance purposes, actuaries would be out of a job, and insurance premiums would be identical for all. The tasks of cost containment and access expansion would not be easy, but the application of uniform cost-containment strategies would stand a chance of being effective and equitable.

The vital fact in this context, however, is that health care expenditures are very concentrated, and a large and predictable part of that concentrated cost is borne by the chronically ill and disabled. The following chart demonstrates the unequal distribution of health care costs in any given year.[156]

1996 HEALTH CARE EXPENDITURES BY PERCENTAGE OF TOTAL U.S. POPULATION



The distribution is terribly skewed. In any year, half the population incurs almost no health care costs. The most expensive 10 percent of the population accounts for almost 70 percent of the health care costs, and the top 2 percent accounts for almost 40

156. The data set for this graph is derived from a 2001 study by Berk and Monheit. Berk & Monheit, *supra* note 13, at 12. *See generally* TIMOTHY STOLTZFUS JOST, DISENTITLEMENT? THE THREATS FACING OUR PUBLIC HEALTH CARE PROGRAMS AND A RIGHT-BASED RESPONSE 9 (2003) (graphically depicting the skewed distribution of health care expenditures); Donald W. Light, Commentary, *Sociological Perspectives on Competition in Health Care*, 25 J. HEALTH POL., POL'Y & L. 969, 972 (2000) (graphically depicting the skewed distribution of health care expenditures).

percent of the costs.[157] A small subset of the population, therefore, accounts for almost all health expenditures in any year.[158]

More significantly, the identity of this subpopulation is largely knowable in advance: people with disabilities and chronic illnesses have continuing, often expensive health care needs that drive a large portion of national health expenditures. People with chronic illness predictably need health care services and consume a large percentage of health expenditures. Therefore, they are of central concern in any attempts to contain health care costs or improve access to health care services. Providing health care services to people with chronic illnesses consumes about 75 percent of direct health care costs.[159] The cost of care for a person with one chronic condition is more than twice that of a person with only acute conditions,[160] and almost six times more for a person with two or more chronic conditions.[161]

Studies that identify the medical conditions absorbing the highest medical expenditures support these data points. In one recent study performed by the Agency for Healthcare Research and Quality, the authors, after detailing the fifteen most expensive medical conditions, observed that, "[n]ot surprisingly, many of the most expensive conditions were chronic diseases."[162] And while several of

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157. Berk & Monheit, *supra* note 13, at 12.

158. This skewing also is replicated in subpopulations. HEALTH CARE FINANCING REVIEW, *High Cost Users of Medicaid Services*, 1996 MEDICARE & MEDICAID STAT. SUPPLEMENT 32 (1996) ("Medicare program spending is concentrated on a relatively small percentage of enrollees with serious medical problems."); John M. Neff & Gerald Anderson, *Protecting Children with Chronic Illness in a Competitive Marketplace*, 274 JAMA 1866, 1867 (1995) (finding that 70 percent of Medicaid costs in Washington State were attributable to the medical needs of 10 percent of participating children).

159. Hoffman et al., *supra* note 14, at 1476; *see also* CENTERS FOR DISEASE CONTROL AND PREVENTION, THE BURDEN OF CHRONIC DISEASES AND THEIR RISK FACTORS: NATIONAL AND STATE PERSPECTIVES 3 (2002) (using the study in Hoffman et al., *supra*); Enthoven, *supra* note 57, at W3-238 (citing Hoffman et al., *supra*). The Hoffman et al. study is now over 15 years old, and despite the importance of national health planning, no additional studies of the cost of chronic care appear to have been undertaken since. Interview with Sean Cucchi, Lead Public Health Analyst, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control (Aug. 7, 2003) (on file with the University of Michigan Journal of Law Reform) ("CDC is not aware of another more current study detailing the costs of chronic conditions.").

160. Hoffman et al., *supra* note 14, at 1477.

161. *Id.*

162. Joel W. Cohen & Nancy A. Krauss, *Spending and Service Use Among People with the Fifteen Most Costly Medical Conditions, 1997*, HEALTH AFF., Mar.–Apr. 2003, at 129, 135. The fifteen most expensive conditions were: heart disease, cancer, trauma, mental disorders, pulmonary conditions, diabetes, hypertension, cerebrovascular disease, osteoarthritis, pneumonia, back problems, endocrine disorders, skin disorders, kidney disease, and infectious disease. *Id.* at 134; *see also* Benjamin G. Druss et al., *Comparing the National Economic Burden of Five Chronic Conditions*, HEALTH AFF., Nov.–Dec. 2001, at 233, 235–36 (showing that

the conditions were acute conditions, the authors emphasized that even there, their "data make it clear that comorbidities, many of which are likely to be chronic diseases, are a major factor in driving health care spending and must be taken into account."[163] A handful of chronic conditions, then, account for a large proportion of medical spending.

Chronic care's share of health spending appears to be increasing. In a recent study, the increase in health spending between 1987 and 2000 was examined to determine which medical conditions were predominant causes of the increase during that period.[164] After adjusting data to control for double counting, the authors estimated that just five medical conditions accounted for 31 percent of increased costs,[165] and that fifteen conditions accounted for 56 percent of increased costs.[166] Dominating both the top five and top fifteen lists are conditions overwhelmingly chronic in nature, such as heart disease, mental disorders, cancer, hypertension, arthritis, and diabetes.[167] A combination of increased prices for treatment and increases in a condition's prevalence led to increased costs of treatment.[168]

Diabetes, a chronic condition and a consensus member of the club of most expensive medical conditions,[169] is an example of a condition giving rise to a host of concerns, both from a clinical and cost perspective:

> Diabetes mellitus is a chronic and potentially disabling disease which represents a major public health and clinical concern. People with the disease are at increased risk of developing chronic complications related to ophthalmic, renal, neurological, cerebrovascular, cardiovascular, and peripheral

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the cost of treatment of patients with one or more of five conditions—mood disorders, diabetes, heart disease, hypertension, and asthma—accounted for 49 percent of the nation's health spending in 1996).

163. Cohen & Krauss, *supra* note 162, at 135.

164. Kenneth E. Thorpe et al., *Which Medical Conditions Account For The Rise In Health Care Spending?*, HEALTH AFF. WEB EXCLUSIVE W4-437 (Aug. 25, 2004), *at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.437v1 (on file with the University of Michigan Journal of Law Reform).

165. *Id.* at W4-440 to W4-441. The five conditions were heart disease, pulmonary conditions, mental disorders, cancer, and hypertension. *Id.*

166. *Id.* at W4-441. In addition to the top five, the other eleven conditions were trauma, cerebrovascualar disease, arthritis, diabetes, back problems, skin disorders, pneumonia, infectious disease, endocrine, and kidney conditions. *Id.*

167. *Id.*

168. *Id.*

169. *See id.*; Cohen & Krauss, *supra* note 162, at 134; Druss et al., *supra* note 162, at 236.

vascular disease. Diabetics, for example, are more likely than their non-diabetic peers to have heart attacks, strokes, amputations, kidney failure, and blindness. As a result of the disease and its complications, people with diabetes have more frequent and intensive encounters with the health care system.[170]

The diabetic condition itself and the array of possible comorbidities make diabetes an expensive condition. A recent study of care for a person with diabetes concluded that the cost of care was $13,243 per year in 2002 dollars, more than five times the cost of care for a person without diabetes.[171] Even when the comparison is adjusted to control for the higher-cost demographic profile of people with diabetes, their care was almost two and one-half times more expensive than those without diabetes.[172] And because their chronic condition makes them so vulnerable to other serious diseases, access to appropriate care is essential to protect the health and quality of life of diabetics.[173]

C. The Effects of Likely Versions of CDHPs

What does a description of chronic care have to do with consumer-driven care? First, chronic care is expensive, and accounts for a very high percentage of annual health costs. Second, chronic conditions are ongoing, often permanent conditions, continuing year to year, to the knowledge of the person with the condition.[174] These two factors must be accommodated in any discussion of the value of consumer-driven care as a cost-containment device. Consumers with chronic illness in CDHPs will know that they have high-cost conditions that require frequent and expensive recourse to health care services. And they all know it too: plan sponsors, government architects of new tax-sheltered consumer-driven plans, and health care providers. How will people with chronic illness

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170. Robert J. Rubin et al., *Health Care Expenditures for People with Diabetes Mellitus, 1992*, 78 J. CLINICAL ENDOCRINOLOGY & METABOLISM 809A, 809A (2004).

171. Paul Hogan et al., *Economic Costs of Diabetes in the U.S. in 2002*, 26 DIABETES CARE 917, 927 (2003).

172. *Id.*

173. *Id.* at 930–31; Rubin et al., *supra* note 170, at 809E.

174. TABER'S CYCLOPEDIC MEDICAL DICTIONARY 329 (5th ed. 1985) (defining "chronic" as: "1. Of long duration. 2. Designating a disease showing little change or of slow progression. Opposite of acute.").

fare? How will the health care finance system fare? These two questions are answered in turn.

1. Bad News for the Chronically Ill—The American health finance system is in terrible shape. Eighty million people suffer at least six months without insurance coverage each year,[175] and the rate of uninsurance is getting worse.[176] The high cost of coverage is undoubtedly a cause of the continuing crisis of uninsurance, and is becoming a drag on the employment economy itself.[177] It is, therefore, imperative that some modifications be made to the health finance system. But the risk of harm to the chronically ill caused by reliance on CDHPs counsels against that move. The health needs of those with significant chronic illnesses are so clearly predictable that the structure of CDHPS can be viewed as simply assessing the chronically ill an annual charge in the amount of the deductible *because* they are chronically ill. Joseph Newhouse, in describing the effect of cost sharing on the chronically ill, observed that "[p]aying the initial cost sharing year after year may also be viewed as inequitable—that is, as a tax on the sick."[178] This tax imposes two risks on the chronically ill: negative health effects and impoverishment.

The high deductibles of CDHPs can cause negative health effects by creating barriers to coverage. These barriers are similar to those examined in the RAND Health Insurance Experiment,[179] which studied the effect of per-visit co-payments. That study determined that consumers faced with co-payments were as likely to forego medically appropriate as inappropriate treatment. Disturbingly, when co-payments were large or the consumers were poor, these choices lead to worsened health outcomes.[180] This bodes ill for the effects of CDHPs on the chronically ill. Those with significant chronic illnesses will likely be required to spend their own funds each year to reach the high deductible insurance. This 100 percent effective co-payment for the substantial portion of coverage between HSA limits and insurance attachment may be at least as likely to lead to refused care as the larger co-payments studied in

175. *See* FAMILIES USA, ONE IN THREE: NON-ELDERLY AMERICANS WITHOUT HEALTH INSURANCE, 2002–2003, *supra* note 24, at 3.

176. *See* Leonhart, *supra* note 24, at A1.

177. *See* Paul Krugman, *America's Failing Health*, N.Y. TIMES, Aug. 27, 2004, at A21 ("[R]ising health care costs aren't just causing a rapid rise in the ranks of the uninsured ... they're also, because of their link to employment, a major reason why this economic recovery has generated fewer jobs than any previous economic expansion.").

178. *See* NEWHOUSE & INSURANCE EXPERIMENT GROUP, *supra* note 82, at 356 (suggesting as a remedy the forgiveness or reduction of cost-sharing for the chronically ill).

179. *Id.*

180. *Id.*; *see also* HALL, *supra* note 82, at 48–49.

the RAND experiment. CDHPs, then, pose a threat of causing reduced utilization of health services for the chronically ill. People with serious diabetes, hypertension, cancer, heart disease, and other chronic illnesses require frequent, coordinated care to maintain their health.[181]

In addition to threatening those with chronic illness with increased morbidity, consumer-driven care also threatens them with impoverishment. Evidence from studies of bankruptcy filings suggests that people with high medical debt—including those with health insurance coverage—are disproportionately likely to become impoverished and file for bankruptcy.[182] The postal worker plan described above permits substantial out-of-pocket costs.[183] A member with individual coverage can incur $4500 per year in out-of-pocket costs, and one with family coverage can incur $9000 per year.[184] In addition to the $9000 out-of-pocket "limit," members must pay any amount charged by in-network or out-of-network providers beyond the plan's usual and customary amount,[185] a 25 percent co-payment for pharmaceuticals,[186] and any penalties assessed by the plan.[187] As large as the out-of-pocket costs could be for a chronically ill person insured by the postal worker plan, the Medicare Modernization Act permits substantially larger costs. The Act permits out-of-pocket maximums of $5000 for individual coverage and $10,000 for family coverage,[188] but (as is the case in the postal plan) the maximum does not include anything beyond the allowable in-network expenses.[189] A plan with a narrowly drawn network or low allowable charges, then, could expose a person with chronic illnesses to out-of-pocket expenses several times higher than the purported "maximum."

181. *See, e.g.*, Rubin et al., *supra* note 170, at 809E to 809F (stating that regular care for diabetics reduces both the rates of medical complications and health care costs).

182. Jacoby et al., *supra* note 143, at 377 (stating that bankruptcy often follows large medical debt).

183. *See* discussion *supra* Part II.A.3.

184. APWUHP BROCHURE, *supra* note 93, at 19.

185. *Id.* at 19, 53.

186. *Id.* at 19, 73.

187. *Id.* at 13–19 (listing penalties ranging from $100–500 for failure to obtain precertification for radiological services or inpatient hospital care, even prior to the attachment of the traditional insurance plan, and not chargeable against the out-of-pocket maximum).

188. Medicare Modernization Act, Pub. L. No. 108-173, sec. 1201, § 223(a), 117 Stat. 2066, 2469 (2003).

189. *See* Notice 2004-2, 2004-2 I.R.B. 269 ("[A] plan does not fail to [qualify for favorable tax treatment under Title XII of the Medicare Modernization Act] solely because the out-of-pocket expense limits for services provided outside of the network exceeds [sic] the maximum annual out-of-pocket expense limits allowed for a [high deductible health plan under the Act].").

People with chronic illness not only risk much in CDHPs, but they gain little for two reasons. First, despite the freedom of choice rhetoric surrounding consumer-driven care, people with chronic illness may gain little ability to choose health care providers not selected by their plan sponsors. When they reach the high-deductible plan, they are subject to the utilization rules as they would be under a traditional insurance program. Before that time, when they are either spending from their HSA or paying their additional out-of-pocket deductible, they may choose their provider. For chronically ill people on the upper end of the health care utilization graph,[190] however, that window of free choice could be but a portion of expected care for any year. And, unless the member wishes to change providers mid-year, the "free" choice of a provider early in the year could lead to substantial out-of-network payments (out of pocket) later in the year.

The freedom of choice even within the consumer-controlled portion of the plan may be subject to a further check. Many consumer-directed plans aid consumers in making cost-conscious selections through internet-based information tools.[191] However, consumer ability and willingness to price-compare physicians and other providers through internet tools has been questioned.[192] In addition, while members can often access participating providers for the plan's discount price even before they reach the attachment point of the high-deductible insurance,[193] out-of-network providers are likely to be more expensive, and as described above, the excess costs of out-of-network providers may not be chargeable against annual out-of-pocket maximums.[194] The combination of these financial incentives to stay in-network approximates the pressures of traditional insurance.

The second reason the chronically ill have little to gain from consumer-driven care is simpler and more obvious. The major financial inducement offered by CDHPs is the chance to gain ownership of HSA funds over time; the Medicare Modernization

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190. *See* graph *supra* Part III.B.

191. *See* Gabel et al., *supra* note 2, at W397 to W399 (explaining that cost containment would be achieved when members shop for providers by comparing prices online).

192. *See* Christianson et al., *supra* note 98, at 1125, 1164 (noting that more research is needed to determine whether consumers are able to make informed decisions on medical care); Jon Gabel et al., *Employers' Contradictory Views About Consumer-Driven Health Care: Results From A National Survey*, HEALTH AFF. WEB EXCLUSIVE W4-210, W4-218 n.2 (Apr. 21, 2004), *at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.210v1 (on file with the University of Michigan Journal of Law Reform).

193. *See* APWUHP BROCHURE, *supra* note 93, at 52.

194. *See supra* Part II.A.3.

Act even permits rolled-over HSA funds to be used as a retirement account.[195] But people with significant chronic illnesses—those to the right on the health care utilization graph—will likely use up the amounts in their HSAs every year and therefore enjoy no financial "ownership" benefit from a consumer-driven plan.[196]

Other financial benefits are possible in the abstract. If CDHPs were substantially more effective at reducing the rate of health care inflation, all members would, or could, benefit from that efficiency in the form of higher wages or lower cost-sharing. The next section argues, however, that such cost savings are unlikely.

In sum, there is little the chronically ill could look forward to in the most likely form of consumer-driven health care. The lure of taking ownership of their HSA funds is unavailable, as they will, and know they will, spend all of the funds in their accounts all or most years on predictable, necessary, and expensive care. Their CDHPs will protect them from out-of-pocket costs no more than any other form of health coverage. If the move to consumer-directed plans largely does not affect health costs, as I argue below,[197] then the obvious cost-saving lever for sponsors is to increase employee cost-sharing,[198] and it is the chronically ill who suffer from that move.

2. *Bad News for Plan Sponsors*—A movement to consumer-driven care, as that movement is emerging in the marketplace, is likely to present significant dangers for people with serious chronic illness. The plans that emerge are likely to be focused on short-term cost-savings, not on addressing the effectiveness and efficiency of care for those with serious health needs.[199] A second flaw in emerging consumer-driven plans is normatively independent of this problem, although conceptually linked. Consumer-driven plans that are emerging and are likely to emerge, shaped by recent legislation and regulatory guidance, will not serve sponsors' main goal—reducing health inflation—because the spending patterns of

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195. Medicare Modernization Act, Pub. L. No. 108-173, sec. 1201, § 223(a), 117 Stat. 2066, 2469 (2003).

196. *See* graph 1 *supra* Part III.B. The same problem will plague those with acute illnesses. *See* George C. Halvorson, *Commentary—Current MSA Theory: Well-Meaning but Futile,* 39 HEALTH SERVICES RES. 1119, 1120–21 (2004) (arguing that people with acute illnesses will not be guided by incentives to preserve spending pool funding because the cost of their care overwhelms those amounts).

197. *See infra* Part III.C.2.

198. *See* Gabel et al., *supra* note 21, at 119–20 (describing the increases in coinsurance and co-payments as other cost-containment moves have failed); Robinson, *supra* note 67, at W140 (describing recent trends in expanded member cost-sharing).

199. *See supra* Part II.A.

members are so skewed. They are likely to fail because, as happened with managed care, the interesting, nuanced, theoretical constructions of consumer-driven care will give way to simple plans that are easy to market and manage, and that implement a stripped-down version of a new health plan model. Marketed consumer-driven care is likely to adopt the portions of the theory that turn over to consumers the authority and responsibility for spending decisions. It is likely to miss, however, the theorists' emphasis on the need to focus on the extremely wide range in needs among consumers—from the many who need little care other than routine examinations to the few who need the lion's share of attention and spending. The likely result are plans designed as though convincing the 50 percent of Americans who account for 3 percent of health costs to be careful shoppers is an accomplishment to trumpet to benefits managers. Focusing on the easy parts of a problem does not solve a crisis; doing so wastes money. We are not likely to see Herzlinger's vision of a health system that focuses on improving care for the chronically ill any time soon,[200] or Porter and Teisberg's vision of health plans being rewarded for seeking out and serving people with serious illness, instead of gaining by shedding any member who might become ill.[201] Would these subtle, complex visions of consumer-driven care work? We cannot learn the answer to this question from the performance of simple CDHPs anymore than we can judge the richness of Enthoven's, Ellwood's, and Havighurst's visions for managed care and managed competition from U.S. health care's HMO performance. The market that adopted a cartoon of managed competition appears poised to adopt a cartoon of consumer-driven care.

Professor Herzlinger's recent compilation of essays on consumer-driven care emphasizes a controversial reorientation of health finance, from expert to consumer control of spending.[202] But Herzlinger and her contributors simultaneously acknowledge the need for any sensible health finance system (if it is to contain cost and provide quality care) to emphasize excellent and readily available care for the chronically and acutely ill.[203] Instead, recent

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200. *See* CONSUMER-DRIVEN HEALTH CARE, *supra* note 7, at 118–21 (describing the need to focus on caring for the chronically ill).

201. *See* Porter & Teisberg, *supra* note 74, at 72.

202. *See* CONSUMER-DRIVEN HEALTH CARE, *supra* note 7, at xvii ("[C]onsumer-driven care is a revolution—a radical turn away from the technocratic, top-down policies that just say no to providers and consumers both in the United States and abroad.").

203. *See, e.g.*, Al Lewis, *Consumer-Driven Health Care for the Chronically Ill*, *in* CONSUMER-DRIVEN HEALTH CARE: IMPLICATIONS FOR PROVIDERS, PAYERS, AND POLICYMAKERS 589 (Regina Herzlinger ed., 2004); Robert E. Stone, *Improving Health and Reducing the Costs of Chronic*

legislative[204] and regulatory[205] actions facilitate the proliferation of simple CDHPs focused on shifting purchasing decisions to consumers instead of on rationalizing and improving care to those who actually use health care services in an ongoing intensive fashion. It is no accident, then, that the early CDHPs are long on transferring responsibility and power to consumers, and short on improving the care of people with chronic illness.[206]

Opportunities will be missed as the market responds to the simple, short-term, cost-cutting aspects of plan design and avoids the complex, long term, and truly innovative aspects of consumer-driven care. But more must be said. This selective adoption of the consumer-driven model does more than omit possibly positive changes; it spells the loss of any opportunity to control costs, unless the massive shifting of costs from sponsors to members is regarded as a form of legitimate cost control. And this failure of real cost-savings can be demonstrated without reference to one of the most discussed areas of cost concern for consumer-driven plans: the danger that they will splinter sponsors' risk pools, skimming the young and well while leaving the older and sicker to traditional coverage.[207] There is little evidence as of yet on risk selection, and what evidence exists is somewhat mixed.[208] Even leaving aside the problem of adverse risk selection, CDHPs are unlikely to save sponsors money. That is, costs are likely to go up even if all members move to a consumer-directed plan.

Diseases, *in* CONSUMER-DRIVEN HEALTH CARE: IMPLICATIONS FOR PROVIDERS, PAYERS, AND POLICYMAKERS 643 (Regina Herzlinger ed., 2004).

204. *See* Medicare Modernization Act, Pub. L. No. 108-173, sec. 1201, § 223(a), 117 Stat. 2066, 2469 (2003).

205. *See* Treas. Notice 2004-2, *supra* note 189.

206. *See* Lo Sasso et al., *supra* note 93, at 1074, 1078 (describing plans with an emphasis on shifting responsibility to consumers); Parente et al., *supra* note 93, at 1095 (same).

207. *See* Jefferson, *supra* note 134, at 713–14 (observing that adding consumer-driven plans may cause an increase in the cost of remaining, more traditional plans); Dwight McNeill, *Do Consumer-Directed Health Benefits Favor the Young and Healthy?*, HEALTH AFF., Jan.–Feb. 2004, at 186, 191 (demonstrating through simulation that the young and healthy benefit from consumer-directed plans); Laura A. Tollen et al., *Risk Segmentation Related to the Offering of a Consumer-Directed Health Plan: A Case Study of Humana Inc.*, 39 HEALTH SERVICES RES. 1167, 1183 (2004) (finding evidence of risk selection with lower-cost members choosing CDHPs and noting contrary suggestions in other studies); Gabel et al., *supra* note 2, at W403 (reporting concerns that the young and healthy will select CDHPs and drive up THE costs of traditional plans).

208. *See* Jinnet Briggs Fowles et al., *Early Experience with Employee Choice of Consumer-Directed Health Plans and Satisfaction with Enrollment*, 39 HEALTH SERVICES RES. 1141, 1146 (2004) (finding some selection bias); Parente et al., *supra* note 93, at 1203 (finding little evidence of selection bias); Tollen et al., *supra* note 207, at 1183 (finding some selection bias); Gabel et al., *supra* note 2, at W403 to W404 (observing that evidence either way is thin).

Consider how consumer-driven care will affect spending for those on the upper end of the consumption curve—the 10 percent accounting for 70 percent of the cost. Those with severe acute and chronic illnesses will incur costs that dwarf their HSA contribution and deductible.[209] Despite the savings gained by transferring these initial costs to the sickest members, sponsors gain no cost-saving value from HSAs for the lion's share of annual health expenditures.

Sponsors are unlikely to achieve cost-savings from low-cost members either. Low-cost consumers possibly will regard the HSAs as first-dollar coverage for their rare and inexpensive needs, loosening any inhibitions they may have had with respect to such expenditures. As they "roll over" their annual unspent HSA amounts, they are free even from contributing their own deductible amounts should they need some care—for a broken leg suffered while skiing, for example. One team of researchers described this problem:

> [I]f the employer contributes 50 percent of the deductible each year to the account, employees who use only preventive services could bank two years of spending account dollars to reach first-dollar coverage by year three. In this case, employees who never exceed their annual personal care account . . . allocations from year three forward could have first dollar coverage up to two million dollars for a lifetime, indefinitely.[210]

Whether low-cost consumers will react in this fashion or not is not yet predictable. It is clear, however, that, at a minimum, sponsors will be diverting the funding required for HSA contributions each year to this low-spending cohort.[211] If an employer adopts a plan like the Postal plan for all employees, it will be devoting $1000 per year to an HSA for all members, including 50 percent of the workers who need almost no health care in the year. Those are funds that otherwise could be devoted to paying for care of high-cost members. Employers, then, will gain no inhibitory effect on

209. *See* discussion *supra* Part III.C.1.

210. Parente et al., *supra* note 154, at 1193 (noting that this consumer reaction is conjecture in the absence of real world experience with sufficient consumers in CDHPs).

211. *See* Gabel et al., *supra* note 2, at W403 ("[Y]oung, healthy people who previously received no payments for medical claims expenses will now receive an annual payment for their [HSA], and these payments will be offset by reductions in payments to sicker people, who use up their allotment.").

spending for the high-cost members, and will likely be increasing spending for low-cost members.

An in-between group of members may react to the ownership incentives as sponsors wish. These members would have no expensive acute or chronic conditions, the obvious high costs of which would clearly signal to the member that his HSA contributions and deductibles will be spoken for immediately. And they would not be in the majority of members who spend almost nothing each year. They must be members with expenses substantial enough to be regarded by the member as significant, but minor enough to make careful shopping worthwhile. For example, families with children likely to suffer minor traumas or childhood illnesses, and people with mild forms of chronic illness such as arthritis or well-controlled behavioral disorders, could expect to incur substantial medical costs each year, but perhaps less than the attachment point of the high-deductible insurance. However, this seems an odd slice of the risk pool to drive revolutionary changes in plan design.

Early experience and regulatory guidance suggest that the market will produce a form of consumer-directed health care not focused on centers of excellence and management of chronic and other high-cost care. Instead, it is likely to focus on the power of consumer responsibility to lessen health cost inflation. Such plans, however, are likely to disadvantage people with chronic illness, a vulnerable population reliant on access to appropriate health care. In addition, they are likely to misfire in their attempt to contain costs. Sponsors might adopt a far-sighted perspective and invest in the research, technology, and network building to permit the health finance system to reward quality and results instead of short-term cost savings. Sponsors faced the same choice in the managed care era and proved shortsighted. Is there any reason to believe the market-driven result will be different this time?

IV. NEXT STEPS

A. Market Adjustments

Consumer-driven care does not *necessarily* lead to these bad results for the chronically ill. The failure to recognize and account for the concentration of health costs could doom consumer-driven

care.[212] But sponsors of health care have substantial tools available to protect the chronically ill while reducing cost.

First, sponsors can create "focused factories" of health care—centers that gather expertise in particular procedures, and that are geared to serve the particular needs of people with serious chronic and acute medical conditions.[213] These centers improve care for the sickest people by reliably providing access to the best physicians and procedures. They save money by providing intensive and chronic care in a coordinated manner, eliminating or reducing the waste that occurs when care is fragmented, such as discontinuous, redundant, or inconsistent care.[214]

This vision of health reform conflicts with America's finance system, which is dominated by employer sponsorship of coverage provided by for-profit health insurance firms. Insurers and sponsors have well-understood incentives to resist becoming excellent at treating the sick, as the sick are expensive, even with excellent coordination of care. It is easier and more profitable to avoid the costly patient than to cover them. The advocates of a sophisticated vision of market-driven care recognize this tension; they recognize that our current finance system cannot provide incentives for insurers to become magnets for sick people. To the contrary, our current system pays for the care of the sickest members of society in a way that insufficiently recognizes the extreme concentration of costs in the health delivery system.

As a second step in incorporating this concentration of costs into consumer-driven care, commentators propose systems of risk adjustment in which plans receive payment commensurate with the needs of each member.[215] Plans then would have incentives to provide excellent care, sponsors would reap the benefits of more efficient delivery of care to people with acute and chronic conditions, and patients would benefit from higher-quality and better-coordinated care.[216] These descriptions are clear-eyed, hardheaded,

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212. *See* CONSUMER-DRIVEN HEALTH CARE, *supra* note 7; Robinson, *supra* note 90, at 1885.

213. *See* CONSUMER-DRIVEN HEALTH CARE, *supra* note 7, at 105–11; Jody Hoffner Gitell, *Achieving Focus in Hospital Care: The Role of Relational Coordination*, *in* CONSUMER-DRIVEN HEALTH CARE: IMPLICATIONS FOR PROVIDERS, PAYERS, AND POLICYMAKERS 683, 689–90 (Regina Herzlinger ed., 2004) (noting that expert facilities improve care and reduce costs by improving skill and experience levels and the coordination of care); Porter & Teisberg, *supra* note 74, at 74–75.

214. *See* Gitell, *supra* note 214, at 690–92.

215. *See* CONSUMER-DRIVEN HEALTH CARE, *supra* note 7, at 80–83.

216. *See* CONSUMER-DRIVEN HEALTH CARE, *supra* note 7, at 79–80; Ann L. Robinson, *The Buyers Health Care Action Group*, in CONSUMER-DRIVEN HEALTH CARE: IMPLICATIONS FOR

and smart responses to difficult problems bedeviling our health finance system. The intelligence and cogency of these discussions, however, should not give us comfort that the emerging consumer-driven health care revolution will succeed, for several reasons.

First, the descriptions of how to create nationwide "focused factories" and implement effective risk adjustments are either vague or dependent on isolated, small-scale anecdotes.[217] The vagueness contrasts with the crystal-clear description of simple CDHPs that shift responsibility to consumers, ignore the extreme concentration of costs, and are geared to cost containment rather than quality. Second, "focused factories" and risk adjustments are not new. They were central to, of all things, the Clinton health plan—not the model fastened on to by the consumer-driven care movement.[218] The importance of what used to be called "centers of excellence" and risk adjustment has been well recognized during the entirety of managed care's dominance, and very little progress in implementing either has been made. The lack of progress can be attributed to the failure of managed care to live up to its theoretical promise when the marketplace's demands for immediate cost-control came to dominate plan design.[219] Consumer-driven health care appears to be off on the same trajectory. Theorists assert that the consumer-driven movement can rationalize a system that fails to provide incentives to efficiently and effectively care for the small minority of consumers who need extensive care.[220] Instead, emerging plans appeal to sponsors who either are confused and believe that costs are smoothly spread among members, or are cynically interested in shifting costs to members under the cover of consumer-friendly reform. Sound familiar? Remember managed care?

As managed care took hold in the 1990s, concerns that cost-containment efforts overbalanced patient care concerns produced a wave of regulation.[221] The move to regulate the free-wheeling managed care industry did not save it, whether because managed

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PROVIDERS, PAYERS, AND POLICYMAKERS 309, 312 (Regina Herzlinger ed., 2004) (describing private risk adjustment).

217. *See* CONSUMER-DRIVEN HEALTH CARE, *supra* note 7, at 107–11; Porter & Teisberg, *supra* note 74, at 67.

218. *See* Joseph P. Newhouse, *Patients at Risk: Health Reform and Risk Adjustment*, HEALTH AFF., Spring 1994, at 132, 139–41 (1994) (discussing risk adjustment in the Clinton health plan); Walter Zelman, *The Rationale Behind the Clinton Health Care Reform Plan*, HEALTH AFF., Spring 1994, at 9, 21 (discussing the value-purchasing aspect of the Clinton health plan).

219. *See supra* Part I.B.

220. CONSUMER-DRIVEN HEALTH CARE, *supra* note 7, at 79–80.

221. *See* Jacobson, *supra* note 29, at 381–83.

care plans had lost trust with consumers, the regulation was poorly done, or the regulatory impulse was inconsistent with the market forces that had given rise to managed care.[222] Perhaps the gulf between the richness of consumer-driven theory and the apparent simple-mindedness of the market can be bridged with consumer-driven health care. The next section will examine the likelihood that regulation consistent with the need for attention to chronic illness can turn the movement away from the myopic view towards simplistic and short-term cost-saving goals that doomed managed care.

B. Regulatory Adjustments

The market appears poised to fail in shaping consumer-directed care. Can regulatory intervention help? This is a difficult task, given the generally anti-regulatory orientation of consumer-directed programs. One possibility is to recognize that subjecting some forms of care to generally applicable, high deductibles is counterproductive. If the routine care needed by people with chronic illness is recognized as medically necessary; the quantum of care needed by those with chronic illness is large enough that the deductibles will not serve as an effective check on excess spending; and access to routine care (e.g., outpatient care for children with asthma) is cost-effective in preventing hospitalizations, then some routine care should be covered under first-dollar coverage. Such an adjustment fine-tunes the rather crude incentive systems of emerging CDHPs, leaving substantial consumer responsibility for elective spending, but encouraging and paying for care essential to maintaining the health and functioning of people with significant chronic illnesses.

The Medicare Modernization Act's treatment of consumer-driven care opens a door to just such a possibility. CDHPs can maintain their tax-favored status, notwithstanding general requirements for high-deductible insurance under the Act, if they provide first-dollar or low deductible coverage for preventive care.[223] This exception recognizes the value of primary care as a means of keeping people well, catching illness early, and prevent-

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222. *See* Jacobson, *supra* note 29, at 381–83; David A. Hyman, *Regulating Managed Care: What's Wrong With a Patient Bill of Rights?*, 73 S. CAL. L. REV. 221, 248–53 (2000).

223. Medicare Modernization Act, Pub. L. No. 108-173, sec. 1201, § 223(a), 117 Stat. 2066, 2469 (2003).

ing more serious (and more expensive) illnesses down the road. The Act's waiver of high deductibles in primary care coverage encourages members to use preventive care even at the expense of careful shopping in health care consumption. The Treasury has interpreted this exception very narrowly, however, limiting "preventive care benefits" almost entirely to screening and diagnostic procedures, and prohibiting first dollar from being used for routine treatment of existing medical conditions.[224] This pinched interpretation clearly missed an opportunity to address a central difficulty in consumer-driven care.

A second possibility is to prescribe what deductible amount is permissible for the chronically ill, instead of prescribing what types of spending must be subject to deductibles. Such regulation is justified on both public policy and financial grounds. As described above, a discrete population of chronically ill in the risk pool goes through their deductible amount each year on spending for predictable, expensive, and medically necessary care—unless, of course, they forego such care.[225] Requiring this cohort to go through the exercise each year of spending through their deductible amount is nothing more than a tax on the sick—a transfer of cost from sponsors and the general insured pool to the chronically ill.[226] Requiring that deductibles for the chronically ill be waived will not impair careful shopping. The chronically ill, knowing they will spend their HSA contribution and deductible amounts each year, have no opportunity to feel "ownership" of these funds; instead, they see the expenditures as painful and expensive rituals required to gain access to insurance coverage. For the same reasons, the sponsors will not experience reduced health costs by imposing deductibles on the chronically ill except for the cost-shift of the amount of the deductible. The mandatory waiving of deductibles is a relatively easy form of risk adjustment that resolves some of the problems of people with chronic illness.[227]

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224. *See* Notice 2004-23, 2004-14 I.R.B. 725 (specifying that "preventive care" for CDHP purposes is limited to periodic health examinations, routine prenatal and well-child care, immunizations, tobacco cessation programs, weight-loss programs, and screening and diagnostic services, but *not* treatment for previously diagnosed illnesses).

225. *See* discussion *supra* Part III.C.1.

226. NEWHOUSE & INSURANCE EXPERIMENT GROUP, *supra* note 82, at 356.

227. Similar regulatory measures could be applied to high out-of-pocket minimums for people with disabilities. *See* Medicare Modernization Act § 223(a) (describing out-of-pocket deductible limits that are only minimums, where sponsors are free to be more generous); *see also supra* Part II.A (discussing the high out-of-pocket limits likely to be attached to high-deductible insurance).

State regulation along these lines is clearly permissible. The Medicare Modernization Act permits CDHPs to have deductibles equal to the amount paid into the HSA, and requiring such protections for the chronically ill therefore would not impair the favored tax status of a plan.[228] Notwithstanding the otherwise broad preemption of employee welfare plans, regulation of insurance is firmly within the ambit of state governments.[229]

There are two potential problems with this plan. First, there is tension between the rhetoric of consumer-directed care as empowering consumers to make spending choices—not the state, sponsor, or plan—and the imposition of mandates on sponsors of CDHPs. This tension reflects the genuine complexity of health finance reform, instead of serving as a refutation of regulation. The second concern is much more troubling. ERISA only protects state regulation of insured coverage, and many sponsors avoid state regulation by self-insuring.[230] There is no reason to believe self-insurance will be any less frequent with high-deductible coverage, particularly if states aggressively regulate it, thereby potentially limiting the impact of regulation.

Thirdly, in addition to looking to the coverage and attachment points of high deductible insurance, regulators could look to HSAs themselves to protect people with chronic illness. The HSA encourages members to be careful consumers by imparting a sense of ownership over the funds, and it softens the impact of the high deductible component of the insurance coverage.[231] The first function does not apply to people with serious chronic illness, as they know they will run through their HSA funding each year and will not have the opportunity to form any attachment to the funds.[232] HSAs do serve the second function for the chronically ill, softening the blow of high deductible amounts; as described above, however, any substantial deductible beyond the HSA amount is an intolerable tax on the sick.[233]

As a fourth possibility, states could require sponsors to close the gap between the spending account and the high-deductible health plan for people with chronic illness by adjusting the annual contri-

228. Medicare Modernization Act § 223(a).

229. *See* Kentucky Ass'n of Health Plans, Inc. v. Miller, 538 U.S. 329, 337–39 (2003) (interpreting ERISA's insurance savings clause broadly); Metro. Life v. Massachusetts, 471 U.S. 724, 741–43 (1985) (same).

230. *Metro. Life*, 471 U.S. at 758 (holding that the insurance savings clause does not permit states to regulate self-funded plans).

231. *See supra* Part II.A.1.

232. *See supra* Part III.C.1.

233. *Id.*

bution. In effect, this is a form of risk adjustment. Sponsors are required to adjust up the amount of the HSA contribution to equal the deductible of the residual insurance, but only for people with chronic medical conditions that will cause them to meet the deductible year in and year out. This functionally regulates the residual insurance to minimize the out-of-pocket amount for the chronically ill, with one major difference. ERISA empowers states to regulate the insured, but not the self-insured plans,[234] splitting the marketplace and permitting different treatment of those who purchase insurance (usually smaller employers) and those who self-insure (usually larger employers). Such regulation would avoid a split with the regulation of HSAs, giving states uniform jurisdiction over all sponsors providing consumer-directed coverage.

ERISA should not preempt permissible state regulation. Although ERISA generally preempts state regulation of employee welfare benefit plans,[235] and programs created to provide employees "benefits in the event of sickness" are generally construed as welfare plans,[236] the United States Department of Labor recently advised that it will not treat HSAs as employee welfare benefit plans.[237] If the Labor advice holds up, states will be free to regulate HSAs without concern of ERISA preemption and could require contribution adjustments depending on the chronic-condition status of employees.[238]

If ERISA does not preempt state regulation, the comprehensiveness of the regulation could create several concerns. First, and most obviously, CDHPs arose in part due to dissatisfaction with the highly regulated health coverage environment. The market's failure to account adequately for the chronically ill blunts this criticism, but the regulation could be sufficiently discordant in this context to render it too unpopular to be viable. Less obviously, but more significantly, risk adjustment methods are less effective and more dangerous when applied in retail fashion—that is, when an employer must adjust upward payments for the benefit of an identified employee. While federal law protects such an employee from

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234. *See* 29 U.S.C. § 1144(b)(2)(B) (2000); *Metro. Life*, 471 U.S. at 741–43.

235. 29 U.S.C. § 1144 (2000).

236. 29 U.S.C. § 1002(1) (2000).

237. UNITED STATES DEPARTMENT OF LABOR, FIELD ASSISTANCE BULLETIN 2004-1 (2004), *available at* http://www.dol.gov/ebsa/regs/fab_2004-1.html (on file with the University of Michigan Journal of Law Reform) (advising that Health Savings Accounts are not "employee welfare benefit plans" within the regulatory domain of the Department of Labor).

238. *See id.* at n.7 ("HSAs are personal health care savings vehicles rather than a form of group health insurance.").

disparate employment treatment because she creates higher costs for her employer,[239] such a move creates dangerous incentives for employers.

Ultimately, several regulatory tools are available to address the likely failure of the consumer-directed market to account for the needs of people with chronic illness. They require an adjustment in sponsors' perception that consumer-directed health care will be free from extensive government regulation, and the new health coverage setting requires the development of new regulatory methods.

C. The Convergence of Plan Design and Financing Reform

Perhaps the problem with consumer-directed health care is not the likelihood of going too far, but the likelihood of not going far enough. The effects of CDHPs on the chronically ill jar us; they seem an affront to the social pooling purposes of health insurance. On the other hand, why shouldn't some health costs—those reasonably predictable and within a person's ability to plan—be segmented from those that are unusual, large, or beyond a person's ability to plan? The consumer-driven plans produced by the cost-conscious marketplace are good at segmenting health costs. That segmentation has considerable appeal. But the plans founder on their inability, or unwillingness, to take into account social equity—the unfairness of imposing on individuals costs of medically necessary health care that are beyond their means.

Advocates of consumer-driven care use retirement planning as a useful analogy. Americans have become relatively comfortable with the 401(k) as a vehicle for retirement funding—why not have consumer control and direction for health care as well? This analogy should be pushed a bit. One problem is that health finance is so much more complex than retirement finance. Retirement needs are relatively uniform—food, shelter, and clothing—and therefore simple actuarial analysis can manage the basics for large popula-

239. *See* 29 U.S.C. § 1140 (2000) (prohibiting disparate treatment against employees "for the purpose of interfering with the attainment of any right" under an employee welfare plan under ERISA); 42 U.S.C. § 12112(a) (2000) (prohibiting disparate treatment in the terms and conditions of employment by reason of disability under the ADA). *But see* Toyota Motor Mfg. v. Williams, 534 U.S. 184 (2002) (narrowly construing "disability" for coverage by the ADA); McGann v. H & H Music Co., 946 F. 2d 401 (5th Cir. 1991), *cert. denied sub nom.* Greenberg v. H & H Music Co., 506 U.S. 981 (1992) (narrowly construing the protections granted by ERISA).

tions. Another problem is that through Social Security, the government has planned a large chunk of retirement for seventy years, and (most) Americans are perfectly happy to leave it as a government task. Upon retiring, all Americans receive a basic level of income support that varies only slightly based on their levels of payment into the Social Security system (and in the case of people who have not worked on the books, on the basis of need). Employment-based, defined-contribution retirement 401(k) plans are private supplements to the government base—something less than a luxury, more than an absolute necessity.

High-deductible health insurance, on the other hand, is essential to any form of health insurance. It is difficult to describe a person as having "health insurance" if she does not have "catastrophic coverage" for unexpected, large, medically necessary care. Protection from medical catastrophe is not a controversial part of financial health planning, just as basic Social Security income benefits are not a controversial part of retirement planning. The former protects people from becoming impoverished or unable to afford necessary medical care, and the latter protects people from the possibility of becoming impoverished or unable to afford the bare essentials of survival upon retirement.

The controversial aspect of health care is the funding of sub-catastrophic coverage—the deductible. This is not a problem in retirement planning because retirement planning is simpler. We do not worry that market distortions will impact spending for basic food, shelter, and clothing, and thereby require complex means to guard against the overstatement of costs. The costs of basic food, shelter, and clothing are easily ascertained, even if the political will to provide the full costs are sometimes lacking. With health financing, two competing forms of discomfort confront us. On one hand, we lack confidence in our ability to ascertain when care is medically necessary—contrast with deciding whether food is necessary for a retiree—so we are inclined to impose a market discipline on providers and consumers incentivizing them to make wise, thoughtful decisions. On the other hand, we are uncomfortable with the imposition of barriers to care when a person has a serious chronic condition that demands predictable, expensive, and medically necessary services. In that case, we are inclined *not* to leave the patient to the vagaries of a loosely functioning market discipline. Instead, we want the person's care to be well-managed—with her input—both to prevent her from suffering needless pain, morbidity, or premature death, and to prevent her necessarily

expensive medical condition from absorbing excess unnecessary cost.

The consumer-driven plans emerging in the marketplace, enabled and encouraged by Title XII of the Medicare Modernization Act and IRS guidance, can form a framework for progress, flawed though they are in their shortsighted present form. The segmentation at the heart of these consumer-driven plans could signal a revolution not merely in health plan structure but in health finance—the allocation of costs and responsibilities for American health care. The government collects and disburses funds for the basics of retirement funding, and with the assistance of employers and encouragement of the tax system, for substantial supplemental funding for retirement planning. With the added complexity necessary to configure financing for health care, the allocation could be similar.

Two related points converge between the theory of consumer-driven care and the theory of managed care or managed competition. Both points are important to the theorists of the respective systems; the refusal to grapple in a serious way with either point contributed to the failure of managed care, and will contribute to the failure of consumer-directed care. First, the great concentration of health expenditures in care for the chronically ill requires "centers of excellence" expert in high-cost care. Theorists of both systems recognize that providing excellent services to people with serious health conditions is necessary both to achieve high-quality care and to address cost concerns where most costs reside.[240] Second, the American health finance market currently is ill suited to foster "centers of excellence." Health plans compete on price, and avoiding high-cost members is the easiest and surest way to achieve low prices. Employers and other sponsors can counter this competitive effect by demanding that plans focus on both low-cost and high-cost members, as sponsors are responsible for both. But sponsors have not demanded this because they over-select for price when picking a plan—in part out of shortsightedness, in part because they have no desire to become the employer of choice for high-cost employees, and in part because the quality measures that would justify higher prices are under-developed.[241]

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240. *See* CONSUMER-DRIVEN HEALTH CARE, *supra* note 7, at 105–11 (discussing the importance of using "focused factories" of health care for expensive conditions); Zelman, *supra* note 218, at 21 (discussing the "value purchasing" aspect of the Clinton health program).

241. Jacobson, *supra* note 29, at 376–81 (describing agency problems arising from employer purchase of coverage).

These points require some structural form of risk adjustment.[242] Sharing the cost of the small number of high-cost members among sponsors allows them to focus on locating excellent, efficient care. And if sponsors demand excellent, efficient care, then plans (however configured) can compete for business by generating "centers of excellence." The concentration of cost in a few patients impels the creation of "centers of excellence," yet the economic conditions for their creation are not present unless some mechanism adjusts the burden of paying for them among sponsors.

How do we get there? Government is the obvious agent for risk spreading. First, pooling risk to create equitable access to necessary care seems a proper government function. Second, a substantial common action problem inheres in dealing with high-cost medical risks. Using the government as an agent of risk adjustment aggregates the risks under one umbrella and allows for the allocation of funds on the basis of quality and efficiency without the blocking point of disparate sponsors' competing financial concerns.[243] Despite the optimism of market advocates for private methods of risk adjustment, and their belief that government cannot serve in this role efficiently,[244] the common action problems inherent in such a venture are sufficiently daunting to make the call the other way.

Consumer-directed care theorists segment care in a way that aligns with assigning the risk-spreading role to the government. Most of the costs of care are "catastrophic" costs—people with high-cost, chronic conditions consume most of the care. That care is not optional, and shopping for expensive, high technology services is a task better left to experts than to individual consumers. This aspect of risk adjustment does not concern inter-sponsor competition.[245] Government can pool the risks and pay providers—centers of excellence—for excellent, coordinated services.[246] As Porter and Teisberg argue, "[p]roviders should be rewarded for competing regionally and nationally to deliver the best-value care

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242. *See* CONSUMER-DRIVEN HEALTH CARE, *supra* note 7, at 170–75 (discussing private risk-adjustment systems); Newhouse, *supra* note 218, at 132 (discussing risk adjustment methods in the Clinton health program).

243. *See generally* Joseph P. Newhouse, *Risk Adjustment: Where Are We Now?*, 35 INQUIRY 122 (1998).

244. *See* CONSUMER-DRIVEN HEALTH CARE, *supra* note 7, at 171.

245. This move also would eliminate a competitive problem faced by American businesses in global competition. Most foreign businesses do not directly carry the costs of health care for their members, but rather provide, along with others in society, funding through taxes and other assessments for care.

246. *See* Porter & Teisberg, *supra* note 74, at 72–73.

for particular conditions or diseases."[247] Through a form of internal markets,[248] government can contract with "focused factories" or "centers of excellence" to provide a choice of high-quality care for the chronically ill; employers can offer HSAs or other forms of financing for care not provided by the government's catastrophic coverage; and employers and individuals can manage routine and sub-catastrophic costs, as employers and individuals now manage retirement income supplemental to Social Security. A needs-tested supplemental program can provide for those unable to supplement the catastrophic coverage.

CONCLUSION

Consumer-directed health care will play an important part in American health finance, if for no other reason than the failure of managed care and other reasonably available alternatives to offer any plausible hope of expanding coverage and reducing costs. There is substantial appeal to consumer-directed care's segmentation of health finance tasks between routine care, low-cost care, and catastrophically expensive care.

But health finance reform makes sense only if it focuses management's attention on care for the chronically ill and reverses the disincentives to include the chronically ill as plan members. Choice, incentives, and autonomy have a place in health plan design. But persons with high-cost chronic illness must be the focus of any reform movement, not an afterthought. If a system creates incentives for providing efficient and effective care for the chronically ill, it will solve the lion's share of the problem. If it shunts this issue to the side, and instead fiddles with incentives for well people to economize, it will fail.

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247. *Id.* at 72.

248. I borrow this term from the British system where the government centrally funds and manages health care. *See, e.g.*, Timothy Stoltzfus Jost et al., *The British Health Care Reforms, the American Health Care Revolution, and Purchaser/Provider Contracts*, 20 J. HEALTH POL., POL'Y & L. 885, 885–86 (1995). Borrowing much more from the British system is difficult. The British system has government control with private contracting the exception, while the American system has private contracting with government control the exception; they "come to contracting from fundamentally opposite directions." *Id.* at 886. However, the U.S. government has experimented in recent years with "internal markets," encouraging competition among providers by selectively contracting on the basis of quality and price. *Id.* at 897–901. The problems presented in this paper suggest that we should consider an exceptional role for government in the financing of catastrophic costs.

The market, however, appears poised to adopt forms of consumer-directed care as though encouraging the well to economize on care is the tough task. Success in that task may be achievable, but to pursue a system based on that goal is a fool's errand. Our health economy made a mistake in adopting managed care; it permitted entrepreneurial, simple-minded, cost-driven forms of managed care to dominate the market, ignoring advice of managed care theorists that these forms of managed care were not up to the task. We should not repeat that mistake by adopting entrepreneurial, simple-minded, cost-driven forms of consumer-directed care. They will subject the chronically ill to risks of foregone treatment and impoverishment, and they will not succeed in reducing health cost inflation. Recognizing the complexities of health finance reform, we should focus on the twin tasks of encouraging the creation of "focused factories" of care for the chronically ill, and adopting a governmental system of catastrophic insurance to ensure equitable funding for such care.