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## Can Consumers Control Health-Care Costs?

Mark A. Hall

*Wake Forest School of Law*

Carl E. Schneider

*University of Michigan Law School, carlschn@umich.edu*

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Mark A. Hall\* and Carl E. Schneider

## Can Consumers Control Health-Care Costs?

**Abstract:** The ultimate aim of health care policy is good care at good prices. Managed care failed to achieve this goal through influencing providers, so health policy has turned to the only market-based option left: treating patients like consumers. Health insurance and tax policy now pressure patients to spend their own money when they select health plans, providers, and treatments. Expecting patients to choose what they need at the price they want, consumerists believe that market competition will constrain costs while optimizing quality. This classic form of consumerism is today's health policy watchword. This article evaluates consumerism and the regulatory mechanism of which it is essentially an example – legally mandated disclosure of information. We do so by assessing the crucial assumptions about human nature on which consumerism and mandated disclosure depend. Consumerism operates in a variety of contexts in a variety of ways with a variety of aims. To assess so protean a thing, we ask what a patient's life would really be like in a consumerist world. The literature abounds in theories about how medical consumers should behave. We look for empirical evidence about how real people actually buy health plans, choose providers, and select treatments. We conclude that consumerism is unlikely to accomplish its goals. Consumerism's prerequisites are too many and too demanding. First, consumers must have choices that include the coverage, care-takers, and care they want. Second, reliable information about those choices must be available. Third, information must be put before consumers in helpful ways, especially by doctors. Fourth, the information must be complete and comprehensible enough for consumers to use it. Fifth, consumers must understand what they are told. Sixth, consumers must actually analyze the information and do so well enough to make good choices. Our review of the empirical evidence concludes that these prerequisites cannot be met reliably most of the time. At every stage people encounter daunting hurdles. Like so many other dreams of controlling costs and giving patients control, consumerism is doomed to disappoint. This does not mean that consumerist tools should never be used. If all that consumerism accomplished is to raise general cost-consciousness among patients, still, it could make a substantial contribution to the larger cost-control efforts by insurers and the government. Once patients bear responsibility for much day-to-day spending on their health needs, they should be increasingly sensitized to the difficult trade-offs that abound in medical care and might even begin to

understand that public and private health insurers have a legitimate interest in controlling medical spending.

**Keywords:** consumer-driven health care; consumerism; health care costs

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\***Corresponding author: Mark A. Hall**, Fred D. and Elizabeth L. Turnage Professor of Law & Public Health, Wake Forest University, e-mail: hallma@wfu.edu

**Carl E. Schneider:** Chauncey Stillman Professor of Law & Professor of Internal Medicine, University of Michigan

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## 1 Introduction

Until recently, insurance spared many consumers immediate concern over the cost of medical care. This was pleasant, but as the gloomy science would predict, when consumers want the best and ignore price, costs soar. And when providers bill for each service they provide – when their incomes depend on selling as many services as possible as expensively as possible – prices will soar even faster and further.

Health-care costs have been thought calamitous for generations. As Tim Jost (this volume 2012) documents, medical spending has been seen as a national problem since at least 1930, when the Committee on the Costs of Medical Care was established by private philanthropies to study the mounting burden. Table 1 documents that, as early as 1960, experts warned that the system was in a crisis, and repeatedly since then. For decades, countless scholars, think tanks, government officials, blue ribbon panels, and the public at large have been desperately looking for solutions (as Table 2 also reflects).

The entities that actually pay insurance premiums – employers and governments – have particularly sought ways to cabin health-care costs without eroding quality. To date, their most prominent attempt has been managed care. Managed care attacks costs primarily by limiting patients' choices of physicians and treatments and by giving physicians incentives to spend less money. Managed care has had some success in controlling costs, but, alas, only temporarily. Ultimately and crucially, managed care plans were driven off by many of the programs intended to save money. That abandonment was caused by hostility from patients who felt that managed care eroded their control of their medical care and from doctors who felt it eroded their control of their work (Hall 2005). So while managed care's successes have been limited and temporary, that does not prove that managed care cannot work. It may simply mean that managed care was abandoned – or at least diluted – before it had fully developed.

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- Marion Sanders, *The Crisis in American Medicine* (New York: Harper & Bros., 1960)
  - Walter Reuther, *The Health Care Crisis: Where Do We Go from Here?* (1969)
  - National Health Forum, *Meeting the Crisis in Health Care Services in Our Communities* (1970)
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  - Alice J. Fisher, *Health Care in the 70's: A National Crisis: A Bibliography of Books and Articles Compiled for the World Affairs Library* (1974)
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  - Charles B. Slack, *Medicine in Crisis* (1983)
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  - Joan Nordquist, *The Health Care Crisis in the United States: A Bibliography* (1997)
  - Jonathan Cohn, *Sick: The Untold Story of America's Health Care Crisis* (New York: Harper Collins, 2007)
  - Tom Daschele, Jeanne M. Lambrew & Scott S. Greenberger, *Critical: What we Can Do about the Health Care Crisis* (St. Martin's Press, 2008)
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**Table 1:** A Sampling of Books about the Health-Care Crisis, From Different Decades.

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- Crisis in Health Care, An Overview (1983)
  - Crisis in Health Care the States' Perspective (1984)
  - The American Health Care Crisis: A View from Four Communities (1990)
  - Hearings on the Growing Crisis in Health Care: the Basic Health Benefits for All Americans Act and Other National Health Care Policy Options (1990)
  - The Health Care Crisis and the American Family (1991)
  - Health Care Crisis: Problems of Cost and Access (1991)
  - The Nation's Health Care Crisis (1992)
  - Health Care in America a System in Crisis (1992)
  - America's Growing Crisis: Access to Affordable Health Care (1992)
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**Table 2:** Some of the Hearings Congress Conducted Over the Course of One Decade a Generation Ago.

## 1.1 Crescendoing Consumerism

Managed care tries to give consumers what they want – good care at good prices – by putting organizational pressure on doctors. Many managed care practices have survived the managed care backlash in some form, yet the crisis of rocketing medical costs intensifies. So, if top-down, supply-side approaches have not given consumers what they want, why not try bottom-up, demand-side approaches? (Hall 1997). Why not treat patients like consumers? Would patients not select the care they want at the price they prefer if they had to pay most of the cost? And, would not the market thus created spur competition that expands consumers' choices while constraining costs? This elemental form of “consumerism” is today's health policy watchword.

Of course patients have been buying medical services since the time of Hippocrates, but until a generation ago, physicians made sure to keep medicine's commercial elements largely hidden (Hall 2008). Then, managed care intensified the movement toward consumerism and competition, partly by hastening the organization of doctors and hospitals into groups that competed for patients. Still, patients did not see themselves as being engaged in a commercial transaction. To change that, proposals now abound for engaging patients much more directly in making their own medical purchasing decisions. Currently, the best promoted proposal is “consumer-directed health-care”<sup>1</sup> in the form of high-

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<sup>1</sup> Such an ugly phrase; such a clumsy label. For brevity's sake, and for euphony's, we will often call it “consumer direction.” This leads us to another nomenclatural problem. We sometimes use “patient” and “consumer” interchangeably. This will upset people – especially doctors – who believe that a doctor's relationship is with a patient, not a consumer, but we want to acknowledge the potential validity of the belief that patients, rather than conferring blind trust in providers, sometimes are better off using their market power to buy good customer service and competent care.

deductible health insurance (Jost 2007). Because of its present prominence, we will direct particular attention to it. But consumer direction is part of a larger set of practices and proposals that vary considerably but use similar methods, make similar assumptions, and raise similar questions.<sup>2</sup> We therefore evaluate consumerism through an “ideal type.”

In this ideal type, consumers make three principal purchases. First, patients choose their insurance and health-care plan. Like good consumers, they decide which plan best suits “their particular needs at the most tolerable price.” And as consumers buy plans, competition for their business drives health plans to offer patients what they want at reasonable prices.

Second, the consumerist program asks patients to choose their doctors, hospitals, and other “providers” with an eye to both quality and cost. This is critical to consumer direction because patients’ spending on health care crucially depends on what providers offer and advise. Consumerism, then, imagines that patients ask several questions in selecting providers. For example: Which providers offer inexpensive services? Which providers work with you to control your expenditures? Which providers treat patients decently? Which providers offer competent – or truly excellent – care? Here, again, consumers already do make some choices – they choose their doctors, or at least their primary-care doctors, but usually not with an eye to thrift (Schneider 1998).

Third, patients decide which treatments to buy. In recent years, steps have been taken to make this choice do important work. In its strong form, consumer direction’s basic idea is that consumers will spend their “own” money, not “insurance” money, to buy treatments and hence will buy with costs in mind. Of course few people can actually pay for all the treatment they might need, so consumer direction assumes that insurance would pay what are usually called “catastrophic” costs. In other words, consumers are to be encouraged to buy insurance with high deductibles or other forms of more aggressive cost-sharing by patients.

Both sides of the ideological spectrum should find something to like in the consumerist agenda. The appeal to the right is obvious – consumerism uses the market to regulate prices and ensure quality. The left should see that the consumerist program fits neatly with the patient-centered principles of bioethics. Offering patients control over their medical care has been the alpha and omega of the law of bioethics (Garrison and Schneider 2003).

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<sup>2</sup> Naturally, the “term has become so widely used that many different concepts masquerade under its banner....” (Nichols et al. 2004).

## 1.2 Considering Consumerism

It is hard to see the consumerist agenda without feeling *déjà vu*. Many attempts have been made to reduce costs, improve quality, and expand control. Attempts to cage costs have failed with discouraging regularity. Improving quality is a dauntingly complicated business. And the principal legal attempts to give patients more control over their health care have routinely disappointed (Schneider 2006). When social policy repeatedly fails to achieve excellent goals despite exceptional efforts, there are usually high and sometimes insuperable barriers, to reaching the goals. Thus it is with consumerism.

To assess consumerism more, our analysis focuses on the thing that makes consumerism distinctive: Everything in the consumerist dream rests on purchasers making good choices. In this article, we will ask whether they will do so. To answer, we need data about how people behave when they buy health care, when they make similar purchases, and when they make medical decisions (Schneider and Teitelbaum 2006). Happily, an empirical literature addresses just these questions abundantly, if spottily. We will therefore ask systematically what it would take for consumers to make the kinds of decisions that would make consumerism successful. Then we will consult the empirical evidence to learn how well each requirement can be met.

For consumers to make good decisions, they need good information, understandable information, information they can analyze well. These conditions can be dismayingly hard to meet in health care. Patients' choices of providers and treatments are sporadic, hard to assess even afterward, and often made in local markets that are too small to work well. All this makes health-care choices harshly more demanding than most other purchases, as Kenneth Arrow (1963) famously observed half a century ago. Backing his foresights with more systematic data, we will conclude that consumerism is based on unexamined and untrue assumptions about what would happen were patients to become consumers in any strong sense. We emphasize this point for two reasons. First, those assumptions have too long been accepted too uncritically. Second, consumerist proposals of a strong kind – like those for catastrophic health insurance – continue to be advanced and applauded with a romantic disregard for what we know about how they are likely to work. This does not mean that consumerist tools should never be used. It does mean that they should not be used unadvisedly or lightly, but discreetly, advisedly, soberly, and in the fear of error.

## 2 Can Patients Make Good Decisions on Their Own?

At the heart of consumerism is the belief that making patients spend their own money for medical care will induce them to buy care at good prices and to eschew care they do not need. This depends, however, on consumers having enough good information about providers and treatments to make intelligent decisions possible. They will need to know what they are being offered, its quality, and its cost. Will all this information be forthcoming? Does it exist from reliable sources?

### 2.1 Does the Information Exist?

Much information consumers might like in choosing providers or treatments cannot practically be compiled, would not willingly be compiled, or simply has not been compiled. Certainly, consumers today are proffered much less information of real value than they need. But in a consumerist world, would consumers' demands induce providers to assemble the information buyers need? To some extent, surely. But much information is surprisingly hard to assemble in a form even experts can use readily. Take one indispensable kind of information there is long experience with – information about what doctors and hospitals charge. This information is simply unavailable in any form consumers could use to compare providers and even treatments. Much of that information is unavailable in any form *anyone* could readily use (Hall and Schneider 2007).

Consider, for instance, hospital's fees. They are levied (at least for uninsured patients) according to a "charge master." It is "a confidential list of charges made by the hospital for all its goods and services" that "is compiled and maintained by the hospital's chief financial officer on the hospital's computer system" (*Doe v. HCA Health Services of Tennessee* 2001). Charge masters contain tens of thousands of items and run hundreds of pages long (Dobson et al. 2005; Reinhardt 2006; Anderson 2007). They are also "confidential proprietary information... not shown to anyone other than the officers and employees of the hospital and authorized consultants." The situation is similar for physicians' services (*Doe v. HCA Health Services of Tennessee* 2001).

*If* you could get a charge master and *if* you could understand it, you would have to decide which of the thousands of charges you would use in comparing providers or courses of treatment. Even if you knew what illnesses you and your



family would have, you would have to know what treatments they would call for, something even a doctor might well be unable to predict. Even if you correctly anticipated the treatments you would need, you would have to identify all their elements as they were broken down in the charge master. Then you would need to have similar success with the charge masters of other providers (Hall and Schneider 2008). Even if you *could* do all this, who would have the desire and will?

Consumer direction may stimulate innovations in payment that provide clearer cost estimates of different providers and courses of treatment. Many managed care plans, for instance, currently pay providers for bundled units of service, such as a fixed rate per period of time (capitation or salary) or per hospital admission. However, there is no obvious way to determine under these simplified payment methods how much the health plan should charge a patient for discrete items of service that are subject to the deductible.<sup>3</sup> Other complications exist under payment methods that are based in part on performance measures such as cost, quality, or satisfaction that are calculated retrospectively. These innovations in provider payment arose under managed care systems where health plans pay providers for a population of patients. Therefore, they have a difficult fit with the consumerist strategy, which contemplates discrete payments from patients as specific services are rendered. The set of agency problems (and potential solutions) between *patients* and providers is fundamentally different than those between *health plans* and providers. Therefore, it is to be expected that provider payment methods designed to minimize agency costs for health plans will not work as well when applied to patients' out-of-pocket obligations. It may, or may not, be possible to adapt innovative managed care payment methods so they can apply effectively to both high-deductible and health plan payments.<sup>4</sup>

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**3** This problem is not unique to high-deductible insurance. It exists in any situation where the provider is obligated to provide services without specific compensation but the patient must satisfy a deductible or pay coinsurance. Moreover, a similar problem exists whenever there is a stop-loss arrangement between health plans and providers who have assumed financial responsibility for certain patient care. In each case, there must be some method for determining how individual items paid for in a bundled or prepaid manner count toward meeting a threshold expense level.

**4** For instance, to address the existing problems, health plans have generally contracted with providers to set a fee schedule that is used, not for actual reimbursement, but only as an accounting tool to track the value of services that count toward the deductible or stop-loss threshold. Negotiations over such surrogate fee schedules may not be at arm's length, however, or market-driven in the same way that actual fee-for-service fee schedules are. In analogous situations, health plans have been sued, successfully, for calculating patients' coinsurance obligations on the basis of provider list prices rather than the discounted prices that the plan itself was paying (*Humana v. Forsyth* 1999). This earlier litigation may create a

But, the payment method most compatible with consumer direction is fee-for-service, and so this will likely be the path of least resistance.

Health plans could negotiate firm global prices from participating providers for treating particular episodes of illness or health plans could contract with centers of excellence for especially difficult and expensive treatment (Porter and Teisberg 2006). Although it is certainly not unreasonable to hope that substantial changes like these might occur in the dynamics of managed care provider contracting, this entails a first-actor problem. Despite the potential gains to consumers, the innovations required to bring about consumer-friendly provider pricing might be so difficult and uncertain that no single firm may be inclined to accept all the risks, knowing that if it succeeds imitators will quickly eliminate the firm's initial market advantage. Therefore, it is uncertain whether consumer direction will ever generate all the innovations that its proponents anticipate for empowering consumers in this way or to this extent.

A foretaste of consumerism is provided by the experience of consumers who pay out of pocket for medical services like *in vitro* fertilization (IVF), cosmetic surgery, and dental crowns. Experts in those markets say that “[c]onsumers engage in little price shopping” for these services. For IVF and rhinoplasty, most consumers choose providers based on previous patients' recommendations or physician referrals. For dental crowns, virtually all patients choose to stay with their regular dentist rather than shop around” (Tu and May 2007). The reason is significant: “accurate price quotes can only be obtained after undergoing in-person screening examinations because costs vary according to patient characteristics and medical needs as assessed by each provider.”

Consumerism cannot go far if consumers cannot evaluate prices. Nor can it go far if consumers cannot evaluate quality. Yet information about quality is as elusive as information about price. One study found that “[j]ust 1 in 7 people (12–16 percent) in all plan types said that their plans provided either type of information [quality or price] on doctors and hospitals...” (Fronstin and Collins 2005). Uwe Reinhardt (2001) gloomily concludes that “[i]nformation on the quality of care is generally unavailable or not trustworthy.” Even infection or complication rates in hospitals are not publicly known. He explains that, “[s]uch information on quality as is made available in the media or on Web sites typically consists of

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precedent for requiring health plans to let their enrollees have the benefit of any discounts they obtain. Indeed, the artificiality of accounting-only fee schedules, together with the fact that they are negotiated by parties with a stake in extracting higher rather than lower payments from patients, would seem to make them dubious grounds for establishing patient obligations based on anything but the best price available to the plan itself.

mysteriously weighted aggregate indexes that obscure the detailed information patients would need in competitive market.” There are only “very limited, opportunities to learn about the health outcomes achieved by particular physicians and hospitals” (Wilson 2001).

Like information about price, information about quality is unavailable partly because it is frustratingly hard to assemble. You might think consumers could at least be told which doctors and hospitals left their patients in better health. But quality is nastily hard to measure. Even mortality rates depend on many things besides the quality of the doctor’s or hospital’s work. Local hospitals often treat patients whose prospects are good and send patients with ominous prognoses to tertiary-care centers, based on factors that are not easily measured and adjusted for in the comparison statistics.

In short, even the basic information consumers need to make intelligent purchases of expensive products – like information about cost and quality – is often not readily available even to experts. Nor is it easy to see how adequate information could be compiled, given the difficulty of ascertaining and compiling it, the reluctance of the sources of information to publish it, the quantity of the information that might be relevant, and the difficulty of deciding which information is actually useful.

## 2.2 Can Information Be Presented Effectively?

Suppose, *arguendo*, that the necessary information about providers and treatments can practically be assembled. Can that information be put into a form that consumers can use to make good decisions?

Patients characteristically far overestimate how much information they really want and actually can use in making medical decisions. In one large-scale study, “[m]ost subjects (76.2%) responded that they would want to hear of any adverse effects [of a treatment], no matter how rare (Ziegler et al. 2001). A greater percentage, 83.1%, responded that they would want to hear of any serious adverse effect, no matter how rare.” Do people truly want WebMD’s whole list of side effects for one drug: excess stomach acid secretion, irritation of the stomach of intestines, nausea, vomiting, heartburn, stomach cramps, bronchospasm, stomach ulcers, intestinal ulcers, hepatitis, stomach or intestinal bleeding, inflammation of skin, redness of skin, itching, hives, rash, wheezing, trouble breathing, life-threatening allergic reaction, giant hives, rupture in the wall of the stomach or intestines, hemolytic anemia, large skin blotches, decreased blood platelets, decreased white blood cells, and decreased appetite? Will people still want the list when they learn that this alarming drug is aspirin?

The attempts to figure out what information people need to choose a health-care plan suggest how challenging the project is. Judith Hibbard and colleagues describe experiments with HMO “report cards” which “use several performance measures and plan characteristics to compare multiple plans.” For example, “the Minnesota Health Data Institute distributed a 16-page, statewide report card that featured comparison tables and color-coded graphs of consumer satisfaction within categories of health plans and compared 38 plans based on 20 performance measures” (Hibbard et al. 1997). However, an assessment of the “report card revealed that less than half of those seeing the report thought it was helpful for deciding on a plan. Consumers found the report cards cumbersome, complex, and detailed” (Hibbard et al. 1997).

All this puts a heavy burden on the authors of report cards to make their information comprehensible. Here we have considerable experience from informed consent forms, privacy notices, and much else. The “readability” of these disclosures has been extensively studied, and the news is extensively bad (McCormack et al. 2001; Paasche-Orlow et al. 2003, 2005; Walfish and Watkins 2005).

So, you say, if report cards are unreadable, make them readable. If the language is sophisticated, simplify it. If the text is dense, prune it. If the page is dull, brighten it. Of course the people who study informed consent, confidentiality forms, and the like have thought of this. And they have tried, for decades. They are able to budge the needle but not to move it far enough. There are high barriers to success here. “Readability” is more than using simple words and syntax. Yet consider just the problem of vocabulary. Experts use technical vocabularies because they efficiently communicate complex ideas. It’s hard to abandon that efficient and familiar means of communication. And it’s hard to gauge which words are Greek to novices. “Patients often do not understand even common clinical terms such as “acute,” “stable,” and “progressive,” and many have difficulty interpreting simple graphs” (Heisler 2005).

As has been true of informed consent, attempts to improve the information patients receive can have *some* success, but this is a long way from *enough* success, from actually equipping patients and consumers to make good decisions. Nothing in the experience of mandated disclosure in other areas should give us confidence that information about health care can be presented to consumers in a form that will permit them to choose intelligently on their own. This is inherent in the complexity of relevant information and decisions, and also in the basic elements of literacy and numeracy required to be adequately informed for any nonsimplistic decision.

Much of the information about choosing providers and swaths of information about choosing treatment are normally in writing. Yet the “1992 National

Adult Literacy Survey..., the most accurate portrait of English-language literacy in the USA, found that 40–44 million Americans, or approximately one quarter [of adults], are functionally illiterate, and another 50 million have marginal literacy skills” (Ad Hoc Committee on Health Literacy 1999). Illiteracy matters in health care: A “third of English-speaking patients at 2 public hospitals could not read and understand basic health-related materials,” and 42% of the patients studied could not “comprehend directions for taking medication on an empty stomach, 26% could not understand information on an appointment slip, and 60% could not understand a standard consent form” (Ad Hoc Committee on Health Literacy 1999). The report concludes, “These limitations on patients’ ability to understand information about disease management, prevention, and informed consent... [mean that] physicians are not successful in communicating essential health care information to their patients, particularly to those with inadequate health literacy.”

Consumers are thwarted not just by illiteracy but also by innumeracy (Paulos 2001). “Patients are increasingly being exposed to quantitative information about risks for disease and benefits of treatment.” Yet (to put it mildly) “many persons do not work well with numbers” (Schwartz et al. 1997). In one study, for example, people were asked to (1) guess how often a flipped coin would come up heads in 1000 tries, (2) calculate 1% of 1000, and (3) to turn a proportion (1 in 1000) into a percentage. “Thirty percent of respondents had 0 correct answers, 28% had 1 correct answer, 26% had 2 correct answers, and 16% had 3 correct answers” (Schwartz et al. 1997).

It is always possible to imagine that the world could be re-arranged to make these problems go away. And no doubt some progress can be made in some places. But the world is the way it is for reasons, and so the world often cannot be improved without strenuous effort. Such efforts have been made in other areas without notable success, and it is hard to see why we should expect anything different of consumers of medical services.

### 2.3 Accepting the Burden of Choice

We now assume away problems of reading. As we have surely established, making good choices in a world of serious consumerism is a laborious business about which people must be prepared to educate themselves. If people do not take on the burden of doing so, consumer direction cannot achieve the goals its apostles promise. That is, working markets need working consumers: if consumers decline to study their choices and to purchase prudently, the market will not provide good services at good prices.

Consumerists generally vaporize this problem by assuming that people who face decisions (1) want to make those decisions themselves (2) after digesting a full plate of information. But people hunger and thirst after decisions much less than consumerists suppose. We know this from our experience in an area where it seems obvious that people yearn to make their own decisions – medical decisions. One study here will stand for many (Schneider 1998). Jack Ende and his colleagues (1989) concluded that “patients’ preferences for decision making in general were weak.” Where 0 meant no desire to make decisions and 100 meant an intense desire to do so, the mean score was 33. Quite significantly, their work found that “as patients were asked to consider increasingly severe illnesses, their desires to make decisions themselves declined.” Like a number of other studies, Ende’s found that younger people were most likely to want to participate in decisions (Schneider 1998).

What is worse, illness corrodes the crafts and arts you need to learn novel and complex things. Patients are exhausted, rattled, discouraged, harried, and hurried. They are absorbed by the commonplace problems of getting through the day that illness exacerbates and on the largest questions of life that illness thrusts before them. All too rarely can patients give enough time and attention to information to assimilate it properly, much less analyze it soundly.

This Ende study resembled other studies in another consequential respect: Patients may not have been eager to make decisions, but they did want information, as we have seen before. Like patients in many studies, they widely said they were anxious to be told about their medical situation. Thus, “the mean score for information seeking was [on the 0-to-100 scale]  $79.5 \pm 11.5$ ” (Schneider 1998). This remarkable contrast between an information score of 80 and a participation score of 33 describes a pattern repeated in various ways in study after study.

The evidence about people’s reluctance to make medical decisions forcefully suggests that we should expect a similar reluctance to make the choices demanded by consumer direction. We have established at some length that health-care choices turn on mastering large amounts of difficult data which can only be acquired with effort when they are available at all. These choices require that people anticipate needs they cannot predict but that are too dreadful to imagine. We now learn that people are widely reluctant to make their own medical decisions, particularly consequential ones. But people who do not want to make a decision are unlikely to do the things that might allow them to make a good decision. As all teachers know, unwilling learners are poor learners.

Thus, although consumers protest that they want loads and loads of information, they shrug off much of what they are given. For example, only 54% “of those enrolled in [high-deductible health plans] who said their plan provided quality

information on physicians said they had tried to use the information. Forty-five percent of adults in [high-deductible health plans] whose plans provided quality information about hospitals had tried to use it... About one-third of those in [high-deductible health plans]...had tried to use plan-provided cost information about doctors or hospitals” (Fronstin and Collins 2005).

The aversion many people will feel for studying and analyzing their choices can have sweeping consequences. We have been arguing that the information is often elusive, obscure, unfamiliar, complex, and saturated with uncertainty. If consumers do not energetically take on the work of mastering these choices and making these decisions, they cannot hope to make well-founded purchases. They would not search out the information, read it, struggle to understand it, survey their alternatives and their preferences, or bring themselves to reach a conclusion.

But how could people take so casually such consequential decisions? People often take their own interests lightly. And people are easily distracted from disagreeable labors. Furthermore, people often have reasons – often good reasons – for delegating even personally important decisions. Take medical decisions. Few people welcome the labor of making difficult decisions, especially when those decisions require them to play for horrible stakes in uncertain circumstances they mistily understand. If people realize they know little about their choices they may fear making mistakes. If people do not realize how little they know, they may make reckless decisions.

We see similar patterns when we ask how well people seek out, learn, analyze, and use information in other circumstances where consequential decisions must be made. A comparison with financial decisions is illuminating. In financial planning, as in much else, “[m]ost of our evidence highlights the importance of passive decision-making. For better or for worse, many households appear to passively accept the status quo” (Choi et al. 2001). This is vividly demonstrated by the experience of companies that used different default choices for employee contributions to retirement plans and found employees sticking with whatever default position they had been assigned. Here again, confidence in one’s own decisions is risky.

Retirement planning provides a particularly good comparison to decisions about health-care plans (Thaler and Sunstein 2008). The former is easy compared to the latter because most people are not wealthy enough to have elaborate investment choices and are best advised to follow a few simple principles – like “diversify!” – that are repeated in pamphlets and magazines unendingly. Nevertheless, “investors often do not recognize how difficult these choices are and instead rely on a belief that their innate abilities will lead to a good investment result” (Choi and Pritchard 2003). Many people do not understand the most basic facts about

or principles of investing for retirement. A “1995 survey by John Hancock Financial Services found that a majority of respondents thought money market funds were riskier than government bonds, and felt that their own company stock was safer than a diversified portfolio” (Benartzi and Thaler 2001). And, people often invest in notoriously dangerous ways.

## 2.4 Choosing Wisely

Suppose, heroically, that ingenuity and perseverance and expense can solve all the problems we have surveyed of assembling, presenting, and comprehending the information people would need to choose providers and treatments effectively. Suppose that consumers have heard and understood the information they have been proffered. Now comes analyzing that information. Consumers in many markets make good decisions because they understand their choices, not least because they have learned from experience in making purchases. But the choices health-care consumers must make range from the manageable to the impossibly difficult. What can we predict about how well people will make their choices?

One problem is that people have difficulty anticipating how they will react to experiences in the future. When they choose providers and treatments they must make decisions about how to respond to risk. It is now a bromide of social science that people have great difficulty estimating the occurrence of events and analyzing risks. In part, this is the problem of hedonic forecasting, about which a bemusing literature has recently developed. It tells us that people have trouble predicting even relatively simple preferences, have trouble anticipating what they will want and how they will react to what they get. People mispredict (to keep the list short) which snacks they will want over the next three weeks, how happy election results will make them, how much better living in California instead of Michigan will make them, how much personal criticism will wound them, and how painful visiting the dentist and other tormenters will be (Garrison and Schneider 2003).

Predicting how you will react to medical conditions is particularly difficult. Consumers usually judge future purchases through their personal experience with past purchases. But personal experience may provide few useful lessons in medical costs because even a series of past illnesses can provoke only a small fraction of the Niagara of possible future treatments.

Let us suppose that when the time to make a decision comes the consumers have heroically surmounted all the problems and repaired all the deficits we have described and still want to take the decision seriously. How well will they



evaluate the relevant information and their chosen goals and assess how well each choice promotes those goals? What we know about how people make decisions about unfamiliar and complex problems is not reassuring: “Making trade-offs to integrate conflicting dimensions into an overall choice is such a complex cognitive task that people tend to use heuristic shortcuts that may not produce optimal decisions. These simplified strategies include selecting only one dimension and ignoring others or focusing on concrete, easy to understand concepts such as cost rather than more complicated and less precise factors such as quality indicators...” (Lubalin and Harris-Kojetin 1999).

This description is confirmed by what we know about the way people choose medical treatments when questions of cost do not loom large. Little in the process by which people make those decisions should reassure us that they are being made well. Patients commonly make decisions so quickly that they cannot possibly use all the information they receive. Indeed, they often make the decision before they hear all the information they are proffered. Patients commonly fix on a single factor and rely on it to the exclusion of other factors.

Ultimately, what matters is whether patients can choose providers and treatments that give them the combination of quality and cost that best suits them and – particularly – that help restrain medical costs. But it’s easy even for patients who are wholly committed to thrift to make penny-wise, pound-foolish decisions. Patients can always save money in the short term by deciding not to consult a doctor. However, early care can be cheaper care. What we want is patients who will make decisions that save lots of money in the long term rather than a bit of money in the short term.

What do we know about how patients make decisions to seek medical attention? It is at least clear that while some patients go to doctors improvidently, others delay foolishly and even disastrously. “Over 30 percent of cancer patients have been found to postpone seeking a diagnosis for three or more months after they first notice growths or other symptoms that they know could be danger signs” (Janis and Mann 1977). Many people having heart attacks delay calling a doctor for four or five hours because “the decision making process gets jammed by the patient’s inability to admit that he is mortally sick” (Hackett and Cassem 1975).

There is some reason to think that some of the time the quality of the patient’s decision will not matter greatly in the long run. For example, tiered copayments and managed formularies for prescription drugs can steer patients and providers toward more cost-effective choices. However, those formularies “are associated with undesirable effects: patients suddenly faced with higher copayments are more likely to switch medications or to discontinue medications entirely. Moreover, studies have found that cost-sharing may be followed by reductions in the

use of “essential” drugs, higher rates of serious adverse events, and increased use of emergency department visits and hospital days” (Neumann et al. 2006; Symposium 2009; Trivedi et al. 2010).

## 2.5 *Deus Ex Machina*: Education

Consumerists answer these objections by invoking the same savior that is going to rescue us from so many other problems – education. If only patients can be taught more facts and more skills, all will be well. Then they will do their consumers’ duty. As Marshall Kapp writes, the champions of informed consent place

much faith...in the potential effectiveness of various educational tools to empower patients to comprehend and manage adequately the basic information needed to satisfy informed consent aspirations. These tools include, among other things: more sophisticated decision aids in the form of information technology; the provision of written handouts to patients; presentation of information in qualitative, quantitative, and graphic formats, simplified to reach the lower literate patient; and the showing of videotapes (Kapp 2006).<sup>5</sup>

This is the triumph of hope over experience. With much skill and labor, these tools can produce statistically significant improvements in patients’ understanding. But they have not and will not bring patients to the point of *adequate* understanding. They show no signs of overcoming the barriers we have been describing.

Consumers remain poorly informed about their own health-care plans even when unusual steps have been taken to educate them. One study, for example, “surveyed adults a year after they were enrolled in a New York State pilot project aimed at expanding health care coverage for the uninsured.” The five plans “made extensive efforts to educate enrollees about the plans” (Garnick et al. 1993). These efforts included “individual in-person enrollment meetings, during which staff describe eligibility and benefits; brochures or videotapes; detailed enrollment contracts; question-and-answer documents in Spanish and English; and, at one plan, a required educational seminar” (Garnick et al. 1993). Nevertheless, “fewer than a third of enrollees could answer all three questions

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5 Professor Kapp cruelly observes that the same people who are so unswervingly faithful to informed consent lose their faith in patient education when the task is to prepare patients to purchase health care. (He argues that education can succeed at both tasks.) Do they have more faith when the task is to educate people to manage their own Social Security accounts under President Bush’s proposed reforms?

correctly; for four of the five plans, fewer than one-fifth could answer all three questions correctly.” Discouragingly, for example, “as few as 29.2 percent of respondents in Brooklyn understood that their plan covered out-of-area emergency care despite explicit wording in the Health Insurance Plan of Greater New York (HIP) handbook,” and “[e]xcept for respondents in Manhattan, fewer than 42 percent of respondents knew that their plan limited their choice of hospitals” (Garnick et al. 1993).

Another point is regularly overlooked but obviously crucial. Education is the Great Solution not just to this problem, but to *many* other problems people cope with and duties they owe. People are admonished to take more responsibility for more decisions in more areas of their lives. An ever-more complex world inexorably presents new things to learn about. The range of choices about even standard products continues to burgeon madly.

The consumer’s task is not just to buy goods and services intelligently. Learning is required in many more areas of life. For example, the movement away from traditional pensions obliges us to learn how to invest for our own pensions (and “privatizing” Social Security would exacerbate that problem nicely). And all this while people still need to learn a good deal about other financial issues, like managing debt. And think of all the things we are supposed to learn about health and safety.

So it is true in some senses that we are increasingly freed from paternalism, for we have proliferating choices about proliferating things. But in another sense, we are increasingly prisoners of the need to learn enough to handle decisions that we make badly, that we would like to escape, and that divert us from activities that we would rather devote ourselves to.

### 3 Doctors as Medical Purchasing Agents

So far, we have discussed patients making purchasing decisions on their own – without the aid of a doctor. The problems in presenting, receiving, and using information may be overwhelming in deciding whether to go to a doctor and which doctor to go to, but once patients get to the doctor, surely they can hope for guidance in making decisions about what care is worth what cost. Doctors will find nothing new in having patients who cannot afford all the care they must have, would benefit from, or just want. After all, they work every day with uninsured and under-insured patients, and even good insurance does not cover all medical expenses. But consumerism contemplates more than just some patients who must worry about costs and more than just patients who

sometimes must worry about costs. Consumerism anticipates that economic pressure will routinely be put on patients, as without that pressure patients would not seek out cheaper care and thus help cabin costs. If doctors do not wholeheartedly devote themselves to helping patients economize, consumer direction cannot rescue us.

But what incentive does consumerism give doctors to make economizing a priority? Health care is often, as economists have said, a world of “supplier-induced demand,” in which the patient’s primary source of information about whether and what care is needed is the very same physician who is being paid to deliver the care or has other personal reasons for believing in its efficacy. There is good reason, then, to question how helpful doctors will be in guiding patients about the best ways of economizing?

### 3.1 Will Doctors Discuss Costs?

Costs presumably can be integrated into conversations with doctors about treatment choices. But who will bring up the issue? Will patients take the initiative and ask whether cheaper treatments are available and whether foregoing treatment is a possibility? This surely happens now, and it surely should be encouraged. But many patients may be reluctant to instigate discussions about costs routinely. For one thing, some patients will be uncomfortable initiating such a conversation. Who wants to bring up money? Patients want their doctor’s approval, confidence, and concern. Questioning a recommendation and requesting something cheaper than what the physician initially recommends and thinks is best would not always strike patients as the best way to establish the relationship they want, especially if the physician you are speaking with is selling his own services.

So if we cannot count on patients to bring up cost, can we count on doctors? Physicians little relish talking about what they charge (Kudlien 1976). The very issue has been of such faint interest (or even so distasteful) that “the literature has only recently begun to address patient-provider communication about health care costs”; on “first pass, it appears that little communication of this type is going on” (Federman 2004). Doctors advertise rarely, advertise fees less, and post no prices. Hippocrates set the example: “Should you begin by discussing fees, you will suggest to the patient either that you will go away and leave him if no agreement be reached, or that you will neglect him and not prescribe any immediate treatment....I consider such a worry to be harmful to a troubled patient, particularly if the disease be acute” (Fabre 1997). Howard Stein (1983) describes a “taboo in official American health culture: namely, a prohibition upon allowing the physician to appear concerned with financial matters.” Introducing money

violates “the sacred by the profane.” Stein believes that people “‘selling’ their services are loathe to affix a price tag to services at the time of the transaction or as an official precondition to ‘delivering’ them. Somehow it would be immoral to do so.”<sup>6</sup>

Despite all this, discussions of cost do occur. Paul Fronstin and Sara Collins found that “[f]ifty-five percent of those in [high-deductible health-plans] reported that they had discussed treatment options and costs with their doctor, and 44 percent said that they had asked their doctor to recommend a less costly prescription drug.” And 43 percent of the patients “in comprehensive plans discussed options with their physician, and one-quarter (27 percent) had asked their doctor to recommend a cheaper drug” (Fronstin and Collins 2005).

This seems encouraging, but those patients were asked whether they had *ever* discussed cost, not whether those discussions were routine and productive. Can doctors’ attitudes be changed so that cost is discussed regularly? Experience in other areas suggests that it is not so easy to alter doctors’ preferences and practices (or anyone else’s), even where there is good evidence that change would benefit patients clinically.

### 3.2 Will Doctors Become Committed to Economizing?

We have been talking as though the only problem is getting doctors and patients to *discuss* costs. Those discussions, if they occur, will be bootless if doctors are not committed to helping patients save money. If doctors are not willing to work heartily toward that goal, patients will make little progress toward it because even independent patients who want to make their own decisions rely heavily on their doctors’ guidance. Doctors influence patients’ choices about tests and treatments enormously. If doctors do not help patients economize – indeed, if they do not lead their patients to economize – patients will be sore pressed to do so well.

How eagerly and thoroughly will doctors economize in treating and working with patients? Several things in doctors’ training, culture, and situation may diminish their willingness to do so. For one thing, economizing sometimes conflicts with physicians’ interests. This reality is what drove us to managed care in the first place, and it still operates, even if less forcefully. Managed care organizations have been trying for years to get doctors to economize in exactly the ways consumerism contemplates. Those efforts provoked vehement resistance from

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<sup>6</sup> This “position has been articulated so frequently to me by apprentice and veteran physicians alike that it might be called official” (Stein 1983).

doctors, less improvement than had been anticipated, and numerous retreats by health plans.

Can patients do better than MCOs? Consumerism, of course, is supposed to enforce economic incentives to economize, but doctors are less regularly and predictably responsive to economic incentives than consumerists seem to suppose. The literature on managed care's attempts to change doctors' behavior through economic incentives suggests that doctors do respond but respond less than an economist might have thought. In short, organized medicine and many doctors have fought long, stubbornly, and bitterly to preserve their unconstrained authority in general and their ability to avoid cost controls particularly.<sup>7</sup> To be sure, doctors were partly concerned that patients were unfairly or unwisely being denied care. But they also were motivated by self-interest – professional and financial. Insofar as doctors are still paid fees for services, doctors will be rewarded for keeping cost-savings off their agenda.

So far, we have been suggesting that doctors have individual and guild interests that may disincline them to make cost containment a priority in analyzing patients' problems and in making recommendations to them. But that disinclination is often reinforced by quite admirable aspects of the culture of medicine. To begin with, doctors are motivated by craft pride in providing optimal care. What is more, doctors are historically committed to what Robert Zussman (1992) calls "Hippocratic individualism," to a single-minded commitment to the interests of the particular patient seeking help. The culture of medicine encourages doctors to think of this interest in medical – not economic – terms. And the culture of medicine points doctors toward providing the best care available, to follow optimal clinical practices, to use evidence-based medicine, to apply the gold standard of treatment.

Furthermore, doctors' paternalism – or less pejoratively, their role – accustoms them to think it their job to persuade patients toward health. Patients fail at surprising rates even to take medications they have already purchased, and patients fail to adhere to more demanding treatment regimes in droves. Inducing patients to cooperate in their own care is part of the physician's stock-in-trade and is something many patients want from their doctors.

Little in this makes doctors receptive to the idea of compromising care simply to save money. Much in this arms doctors to resist lowering medical standards. This commitment may bend a bit to fit economic circumstances, but so far it

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<sup>7</sup> Nor can we count on organized medicine to propose constructive alternatives. Rather, "providers have spent too much of their time complaining about managed care and too little time considering whether alternatives to existing payment arrangements might make everyone better off" (Hyman 2000).

has relaxed less than many economists might like. Our interviews with seven primary-care physicians confirmed the reports of published studies (Mort et al. 1996) that doctors are reluctant to omit necessary care because of costs to the patient. Sometimes doctors are so resistant to reducing optimal treatment that they will, for example, fudge the truth with insurance companies to obtain coverage (Freeman et al. 1999; Wynia et al. 2000; Werner et al. 2004). In short, foregoing care to conserve costs conflicts with much that is elemental in the training and culture of doctors.

The problem of reducing costs is intensified by that fact that much that is elemental in the training and culture of doctors promotes patients' interests and even preferences. Patients may want to save money, but they also do not want doctors to honor patients' own foolish economizing preferences that patients themselves would later regret. This leaves doctors in the delicate position of having to make tricky calculations about when to press a patient to economize and when to press a patient to spend. Thus, we have found doctors most willing to save money when it does not conflict with medically optimal care, as when a patient is likelier to take prescribed medication if the doctor chooses a cheaper, even if less effective, drug. Doctors appear much more willing to accede in patients' thrift where the goal is to control symptoms the patient can perceive and where long-term or irreversible harm is not likely – for instance, control of arthritis pain or medications to slow down the onset of dementia.

But where patients cannot detect symptoms and where bad decisions are difficult or impossible to correct (controlling blood pressure and cholesterol are classic examples), doctors are more inclined to push patients to accept treatment or to make special efforts to provide care at reduced costs. The physicians we interviewed gave examples of pressuring reluctant patients to accept treatment, efforts that varied from persuasion to manipulation to coercion. One doctor, for instance, told a patient who balked at a mammogram that he was going to schedule one anyway. One pediatrician called a taxi to take the patient to the hospital when he feared the parents would just go home. Another doctor calls family members when necessary to enlist them in convincing recalcitrant patients. Still another doctor recalled telling a patient who was reluctant to leave her grandchild in order to come in for an examination that, if she did not, she might die, and “then who will take care of your grandchild?”

We have been surveying some of the factors that may make doctors hesitant to embrace full-court participation in cost-saving. Despite these factors, doctors are not flatly unwilling to help patients save money. Not at all. For example, three quarters of the doctors questioned in one national survey said they routinely considered insured patient's out-of-pocket costs when making some clinical decisions, especially when prescribing drugs (Reichert et al. 2000; Wynia et al. 2003; Hoangmai et al. 2007).

In our interviews, and in our work with medical colleagues, we have encountered many physicians who are warmly anxious to assist patients who have trouble paying for care (Hurst et al. 2005). Furthermore, the changing structure of medicine and the persistent crisis of rising costs have for decades now been pushing doctors toward thrift. For example, 15 years ago Zussman (1992) detected a “more or less thorough triumph of a utilitarian ethic over Hippocratic individualism in intensive care” which was “accounted for...by a scarcity of resources” and “an attenuated relationship between doctor and patient.”

If high-deductible health insurance became common, doctors might come to accept that many patients were paying out-of-pocket and might become more active in helping patients save money. And if doctors believed that they could develop a reputation for inexpensive care that would draw patients to their practice (an uncertain thing, given the way patients choose doctors), they might try to help patients be thrifty out of self-interest. Furthermore, doctors may be more willing to work to reduce costs in a consumerist world than in the world of managed care because in the consumerist world patients individually benefit directly from cost savings, while in the former world any such benefit was much more indirect.

On the other hand, the experience with managed care does not suggest that physicians will swarm to these positions. Even when doctors responded more favorably to managed care, they did not respond in the way consumerism intends and expects. Many doctors, rather than adjusting their recommendations to each patient’s individual insurance situation, changed their style of practice across the board for all patients (Alexander et al. 2006). Economists celebrated the efficiencies of this “spillover effect” of managed care, but it fits badly with consumerism’s expectation that patients and doctors will make efficient decisions, decisions adapted to each patient’s circumstances and preferences.<sup>8</sup>

## 4 Combining Managed Care with Consumer Direction

For the reasons we have described, consumer direction brings costs home to patients, but not in a way that seems likely to permit them to take well-targeted

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<sup>8</sup> Similarly, the people who designed Medicare’s 1983 adoption of “diagnostic-related groups” imagined that DRGs would cause hospitals to focus differentially on more and less profitable services. Instead, DRGs led hospitals to economize more or less across the board, for all patients, including non-Medicare patients (Frankford 1993).



control of their expenditures. At least, consumer direction does bring some costs home to patients, however imprecisely. As Fronstin and Collins report, more than “60 percent of those in [high-deductible health plans] strongly or somewhat agreed that the terms of their health plans made them consider costs when deciding to see a doctor when sick or fill a prescription....” By comparison, “less than 40 percent of those in comprehensive plans felt this way....”<sup>9</sup>

Thus, consumerism clearly produces some of the effects intended for it in some measure. High deductibles and copayments help to increase consumers’ awareness that health care actually costs real money and thus to diminish the extreme entitlement mentality that affects most employee/consumer/voter attitudes toward health care. Perhaps this will help people realize that costs will not be controlled until they get help in persuading doctors to make systematic efforts to contain costs. How might that be done? In a word (or two): managed care.

The health plans that provide residual “catastrophic” coverage also have an interest in helping patients spend their own funds wisely. Therefore, the same payment rates that health plans negotiate for themselves also apply to amounts that patients pay under the deductible. Likewise, treatment protocols and provider incentives that health plans create to conserve patient-paid funds will also delay the onset of the health plan’s own liability once the deductible is met. For these various reasons, patients and health plans, rather than being mostly at odds with each other as they were under classic managed care, now share common economic interests under consumer-driven health insurance. Accordingly, the tools of managed care that patients once opposed so vociferously might now be viewed in a different light.

Although it is too much to expect sick patients to ever view their health plan as their friend, the consumerist movement should in time help the public to see the health plan’s side of many situations. Having been made aware that health care is complex and uncertain as well as very costly, people may finally come to appreciate not only the need for reasonable limits on patients’ and providers’ freedom to tap into the premium pool, but also the help that health plans can give them and their doctors in making reasonable medical spending decisions.

One way to heighten a sense of common interest between health plans and patients is for health plans to share with subscribers some of the immediate

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9 Similarly, 60% “of those enrolled in [high-deductible health plans] said that they had checked whether their health plan would cover their costs prior to receiving care,” while 49% “of those in comprehensive plans had checked whether their plans would cover care and 23 percent had checked the price of a service” (Fronstin and Collins 2005).

financial savings from avoiding excessive medical costs. Health plans could do this by shouldering some (rather than none) of the costs of otherwise covered treatment, even if it does not meet utilization management criteria. For example, rather than deny coverage outright for failing to obtain pre-authorization for hospitalization or failing to receive a gatekeeper's referral to a specialist, the plan could impose only an additional cost-sharing component, such as \$500 for an unapproved hospitalization, or \$50 for an unapproved specialist visit.<sup>10</sup> Similarly, for treatment the health plan deems to be not medically necessary, it could agree to pay (or credit toward the deductible) an amount corresponding to the course of treatment that it deems would have been appropriate.

Consistent with the consumer-driven philosophy, managed care plans could thus conduct their utilization management in a manner that presents patients with a reasonable choice: either full coverage by following the plan's recommended course of treatment, otherwise, some but only partial coverage. Structurally, this is the same type of choice patients have when deciding whether to seek care outside a PPO or point-of-service network. Coverage is available in either event, but nonnetwork providers cost more for both the health plan and the patient, so they both have a stake in constructing a good network and using it most of the time. Similarly, if health plans agree to pay for at least a portion of treatment costs even if full coverage is denied, this will attenuate the financial conflict of interest between subscribers and utilization managers when they make coverage determinations.

Whether using these innovative techniques or only plain vanilla cost controls, our basic point is that managed care is not at all antithetical to consumer direction. Managed care has the potential to correct some of the core deficiencies of consumer direction, such as by motivating providers to act more as medical purchasing agents. Just as important, high-deductible health plans should help to ease patients' natural resistance to – and perhaps encourage their acceptance of – cost controls imposed by government or private insurers.

Managed care by itself failed to control costs, and we predict so too will the ideal version of consumer direction. Neither by itself is it sufficient to conquer the cost dragon, but perhaps their combined forces could at least shift the momentum (if not win the war outright).

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**10** For unapproved treatment subject to the deductible, these amounts would be deducted from the costs of treatment that are charged to the deductible. Also, this additional cost-sharing would not count against the plan's out-of-pocket maximum.

## 5 Conclusion

The empirical evidence about consumers' and patients' experiences suggests that for consumer direction to achieve the aspirations of its advocates, the health-care system, consumers, patients, doctors, and hospitals would have to change in numerous and unlikely ways. Consumerism is supposed to lead people to make good decisions. We have shown how difficult it is to achieve that goal. The goal will be even more elusive if people's distaste for consumerism leads them to resist it.

To be sure, the American public has itself (partly) to blame for consumerism. The international experience is that government intervention is needed for consistently effective cost control (Callahan and Wasunna 2006), yet the American public will not stand for government regulation of expenditures. Nor can it agree on how to provide universal health-care. It helped sabotage managed care. This pretty much leaves consumer direction as the only device for trying to tame health-care costs (Hall 1997).

This self-defeating approach is understandable. Health-care finance is complex and arcane, and a fully informed political discussion of it is unimaginable. And faced with illness, people naturally wish to see it cured, almost whatever the price, especially because the price has for so long been so completely obscured by insurance whose premiums patients did not visibly pay, or paid only fractionally. What is more, the public has been incited in its misunderstanding and indignation by institutions which are less easily pardoned – the medical establishment.

As for ourselves, we are grateful to be living in a market economy and cherish the market's ability to provide – so often – good things at good prices. If consumer-directed health care showed real prospects of delivering what its zealots promise, we would cheerfully try the experiment. And we think that any successful health-care system will make market devices part of its repertoire. But when a resource so basic to human well-being – indeed, to human life – is so scarce for so many people, we need to think more broadly about our social responsibilities. The attempt to give individuals more control over their health care – whether through the market or through the various kinds of mandated disclosure – is proving neither successful on its own terms nor consonant with our responsibilities to our fellow citizens. In this way, consumerism shares the moral failing of much contemporary health politics. It is devoted to serving industry and not society.

As long as consumer direction is viewed only as a way to prompt more informed and efficient point-of-service spending decisions, we doubt that it can do very much alone to rationalize medical spending. Specifically, it will achieve

very little for the many patients who lack the confidence, cognitive skills, or inclination to participate actively in such choices, and very little for the portion of medical spending beyond the deductible. On the other hand, if the stated goal of the consumerist movement were enlarged to include a general raising of cost-consciousness among consumers of health care, it could make a substantial contribution to the larger efforts by insurers and the government. Once patients bear responsibility for much day-to-day spending on their health needs, they should be increasingly sensitized to the difficult trade-offs that abound in medical care and might even begin to understand that public and private health insurers have a legitimate interest in controlling medical spending.

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