

# Consumer-Directed Health Care

*What Does It Mean? Where Are We Headed?*



Grace-Marie Turner



Center of the American Experiment is a nonpartisan, tax-exempt, public policy and educational institution that brings conservative and free market ideas to bear on the hardest problems facing Minnesota and the nation.

**CONSUMER-DIRECTED HEALTH CARE**  
*What Does It Mean? Where Are We Headed?*

**Grace-Marie Turner**

**Center of the American Experiment  
Luncheon Forum**

**Hilton Minneapolis  
Minneapolis, Minnesota  
November 1, 2006**

---

**Introduction**

**Mitch Pearlstein, Founder & President, Center of the American Experiment:** Today's Luncheon Forum on health care is American Experiment's first in a multi-year project of research, publications, public programs, and advocacy under the alliterative, if wordy title: "Stopping Boomer Health Care Budgets from Going Bust: The Imperative of Taking Greater Advantage of Markets, Families, and Faith in Assuring First-Rate and Affordable Health Care for the Coming Surge of Seniors."

At the heart of the project are questions like these:

Why and how must we better rely on free markets, personal responsibility, generous families, and religious organizations if we are to keep immense spending increases as non-crippling as possible in a country which already has the most expensive health care system in the world?

And at root, why and how must citizens retrieve responsibility from governmental agencies for their own well-being and that of loved ones as we all grow old?

Why is all of this so important? Here's just one set of projections.

Unless policy-makers take essential but exceedingly difficult steps, Brian Riedl of the Heritage Foundation envisions federal revenues down the road totaling 18 percent of Gross Domestic Product, while federal (non-interest) *spending* totals 28 percent of GDP. This 10-

percentage-point gap, he predicts, would lead to budget deficits large enough to increase the national debt from 40 percent of GDP to more than 300 percent.

So what to do? Given today's topic, particularly regarding markets?

Present and future attempts to improve health care efficiency and, therefore, access will fall short in Minnesota and nationally unless consumers—be they young or old, covered by Medicare or Medicaid or not—are afforded reasonable choices in selecting physicians, hospitals, and other providers.

Unless potential providers are freer than they currently are to enter often cramped markets.

Unless consumers have convenient ways of learning about prices charged and success rates realized for specific services and treatments by specific providers.

And unless tax and other policies, such as Health Savings Accounts, cause consumers to become more sensitive to costs which, because of an over-reliance on third-party reimbursements, *feel* to be smaller than they really are.

Showing the way on all that, it goes without saying, is an immense order. Might there be somebody out there, somewhere able to lay out a reasonably detailed map, say, in 30 to 35 minutes, then tying up loose ends and mileage markers in another 10 or 15 of questions and answers?

Some job. But would we have invited all of you here today if the incisive Ms. Turner were not in town and free for lunch?

Grace-Marie Turner is president of the Galen Institute, a public policy research organization she founded in 1995 to promote an informed debate over free market ideas for health reform.

She is also founder and facilitator of the Health Policy Consensus Group, which serves as a forum for analysts from market-oriented think tanks around the country to analyze and develop health policy recommendations.

Among her other national assignments, Ms. Turner is a member of the National Advisory Council of Healthcare Research and Quality. She was appointed by Health and Human Services Secretary Mike Leavitt to a panel charged by Congress with making recommendations for modernizing Medicaid. She was invited by President Bush to speak about consumer-directed health care and health savings accounts at a White House Economic Summit. And in the mid-'90s, she served as executive director of the National Commission on Economic Growth and Tax Reform, better known as the "Kemp Commission."

Please welcome a former journalist, congressional and presidential-campaign press secretary, association director, Heritage Foundation vice president, consulting firm president, and soon-to-be medical miracle worker—Grace-Marie Turner.

**Grace-Marie Turner:** We started talking about consumer-directed health care in the early 1990s, when it was not really a very well known term. The situation we faced reminds me of a story about an elderly gentleman living on the outskirts of Los Angeles. He wanted to go into the city for a meeting, and his wife was saying, "You know, the traffic is terrible, your driving has been a little shaky, and I'm really not sure this is a good idea." He insists on going. She says, "Well, at least take your cell phone." "Okay, okay, I'll take my cell phone." After he leaves the house, his wife is listening to the traffic report on the radio and she hears, "There's a huge problem on Interstate 5." So she calls her husband and says, "Honey, be

very careful. Avoid I-5 if you can, because there's somebody going the wrong way on the freeway." He replies, "One? Hell, there are hundreds of 'em!" That is how we felt in the early 1990s when we were talking about consumer-directed health care. It's quite different now, seeing the traffic turning our way.

The vision of consumer-directed health care is to engage consumers as partners in managing health care costs and getting the best value for their health care dollars. That doesn't mean getting the cheapest health care; that means getting the best value. We need new tools, new incentives, and new financing structures to engage consumers in that process. We've had a very paternalistic health care system for the last 30 years, and engaging consumers to become informed about where they're going for their care and how much they're paying is essential to transforming our system. A lot of studies show that if consumers are aware of just some of the costs and are given new incentives, then that translates into their seeking and getting better value even when insurance is paying. We have a long way to go, both in terms of people wanting that information and in terms of having that information available. That said, a growing number of companies are trying to engage their employees as partners in managing health costs, offering better and more accessible information, products, and services that help consumers to spend health care dollars more wisely.

Nonetheless, there's huge momentum for moving toward a single-payer system. In California, for example, both houses of the legislature recently passed bills that would have created a single-payer health care system for the state—with no more private insurance and with the government making decisions about coverage. It was vetoed by Governor Schwarzenegger, but it shows that there's a great deal of energy toward moving to single-payer. One reason for that momentum is that people are fed up with rising costs, are throwing up their hands and saying, "You know, we've tried the private market for health insurance, and it's not working. We have 47 million people without health insurance. Clearly, we need to do something different."

People ask, “Okay, what other country has gotten this right? What other country should we use as a model for health reform?” Yet we can’t compare the United States to other developed countries with socialized health insurance systems, virtually all of which have smaller, more homogeneous populations and often operate with centralized, global budgets. Americans would not tolerate the restrictions people face in other countries. We really need to figure out how we are going to get this right *in the United States*.

This is important not only because of the rising number of uninsured in the U.S., but also because of rising middle-class anxiety. If we don’t do something to moderate health costs and begin to provide health insurance for more of the uninsured, I believe we are going to have a much greater risk that people are going to give up and say, “The government just needs to take it over.”

On the other hand, the movement toward consumerism in health care is also taking hold throughout the developed world. People have more information about health care options, and they don’t want bureaucracies to stand in the way of their getting the care they need.

So I think we are on the cusp of a major decision in this country about who will control our health sector in the future—government or consumers. Needless to say, I favor the latter and would like to describe some of the tools to develop this movement toward consumerism in the U.S. For example, I would like to share with you some of the early evidence about how health savings accounts are working and how the whole consumer-directed health care movement is starting to transform the health sector. Then we can have a conversation about whether this works and ask where we are going. I think we are really down to the wire here; either we’re going to figure out how to make the free market work, or we’re going to default into much more government control, much reduced access to new treatments and medicines, much reduced access to physicians, and much more centralization.

## Early Evidence

Health costs are the linchpin. Right now, we have a system in which most people haven’t the vaguest idea how much of their compensation package at work is going to pay for their health insurance. The Kaiser Family Foundation recently calculated that if you have family coverage with your job, the value of your compensation package attributable to your health insurance is about \$11,500 a year, on average; about \$4,200 if you have individual coverage. Most people haven’t the smallest idea that that much of their pay package is going to finance their health insurance coverage.

But employers know. I’m an employer, and when I hire somebody, I know I’m not just thinking about what this person is going to take home; I’m thinking about what taxes I have to pay and what benefits I’m providing. Labor Department numbers show that take-home pay is suppressed because of ballooning health costs. People know health costs are high, but they often don’t understand that is one of the reasons their pay raises are smaller.

Part of the motivation for companies moving to health savings accounts and other consumer-directed options is that they begin to put more decisions about health spending in the hands of consumers, primarily for routine care. Health savings accounts were enacted as part of the Medicare Modernization Act, signed into law by President Bush on December 8, 2003. The first HSA was sold on January 1, 2004. I think it’s remarkable that companies were able, just three weeks after the law’s enactment, to produce this product, get it on the market, and sell it.

Health savings accounts allow you or your employer, or both, to put money into a tax-protected account. The money goes in tax-free, the inside buildup is tax-free, and the money stays tax-free as long as it’s spent on health care, whenever you spend it, for your whole life. HSA savings roll over from year to year, unlike the flexible spending accounts that a lot of us have had for the last couple of decades where you must spend it or lose your money at the end of the year. HSAs are more like an IRA. The money stays

with you, and, with an HSA, you can take that account with you when you leave or change jobs. So it's really and truly a savings account. There's nothing like this, by the way, anywhere else in the IRS code, where you have money that goes into an account tax-free, the inside buildup is tax-free, and the money stays tax-free as long as you spend it on health care. Even with IRAs and 401(k)s, you've got to pay taxes on it somewhere. The HSA money stays with you and can become savings to help you with expenses even after you retire.

You can use your HSA savings to pay for routine medical expenses, or you can save it and begin to create your own reserve for higher health care expenses you may have later in life. But you can't open a health savings account unless you purchase qualifying, high-deductible health insurance. Many people find they save enough on premiums from the higher deductible insurance to fund their HSA. Although many people see HSAs as a very different new health insurance product, I don't see it that way. You can cover routine bills from your health savings account and you have standard health insurance coverage for larger bills. Instead of having a deductible at the bottom, you basically move your deductible to the middle. And because Congress didn't want to discourage people from getting preventive care like screening tests or drugs to prevent strokes or heart disease, preventive services can be covered by your insurance.

So what's not to like about this? Well, a lot of people don't like it. California Rep. Pete Stark, a Democrat who is on [and now chairs] the influential Health Subcommittee of the House Ways and Means Committee, has said, "HSAs are an effort to shift even more of the cost to individuals while providing tax benefits skewed to those with higher incomes. It's more clear than ever before that HSAs are a tax shelter for the healthy and wealthy, nothing more, nothing less." He does not like HSAs.

Some HSA opponents argue that they are just for the young and healthy. In reality what you find is that enrollment by age follows pretty much a bell curve. Young people are as likely as middle-aged

people to enroll. (Those older than 65 cannot contribute to HSAs.) You find a little spike in enrollment in HSAs among people aged 45 to 55, because these people know they're going to need some health care, they have some time to start saving in their HSAs, and they're more sophisticated health care purchasers.

And we see a similar bell curve in enrollment by health status. One of the reasons that people with chronic illnesses see health savings accounts as valuable is that they know more about what they need from the health care system and like having that predictability of cost. One of the provisions in the health savings accounts law is that annual out-of-pocket expenses are capped. People with chronic illnesses know that their maximum out-of-pocket expense for an individual is going to be no more than about \$5,000, and \$10,000 for a family. So the predictability of costs for those with chronic illnesses is valuable. Another thing they tell me is that they like not having to play "Mother-May-I" medicine—they can see the physicians they want, and they are less constrained by restrictions in accessing care.

America's Health Insurance Plans (AHIP) has done a study of health savings accounts—this is the trade association of the major insurers that offer HSA-qualifying health insurance. In the first six months, about 400,000 people bought the insurance associated with health savings accounts. After the first year, 1.2 million. And after the second year, about 3.2 million. We're expecting that it will be about 6 or 7 million starting in January 2007, which is pretty good market penetration for something that's been so pilloried in the press. It's catching on.

When HSAs first went on the market, there were a lot of individuals who weren't in any other insurance contract, so they had flexibility to move quickly into the HSA market. A third of the people buying health savings accounts initially were previously uninsured. So suddenly, we see something that is actually helping to reduce the number of uninsured. Assurant Health, which sells to individuals and microbusinesses, found even higher numbers of people purchasing health insurance who were previously uninsured: 43

percent. They have found that a third of their purchasers made less than \$50,000 a year, and 62 percent were over age 40. This data also show that you've got a pretty good cross-section of people purchasing HSA insurance.

MacKenzie did an in-depth study looking at the market for consumer-directed health care and found that people with these products were 20 percent more likely to comply with treatments for chronic illnesses. They asked what the incentive was, and people said, "Well, I know that if I take better care of myself, I'll save money in the long run." That's the incentive we want, isn't it? Here, finally, we have a product that uses a financial incentive to get people to do the right thing with their health care. Study after study has shown that people with these accounts are more likely to engage in preventive services, and they're more likely to comply with their prescription regimens, because they want to save money. They don't want to go to the emergency room; they don't want to have to have surgery; they want to take better care of themselves. They're more likely to engage in healthy behaviors, more likely to get physicals, and 50 percent more likely to seek less expensive care.

A lot of companies in the consumer-directed health care world are reaching out and finding patients who are either diabetic or pre-diabetic or at risk of heart disease and therefore stroke, and they're doing a better job of profiles so they can offer special services. So these new consumer-directed health care products are actually doing a better job creating new tools and incentives for people with chronic illnesses to take better care of themselves.

Deloitte said that they believe that about 43 percent of employers are going to be offering consumer-directed plans of some sort within the next couple of years. Human resource directors are sort of skittish, but CEOs can't help but look at the bottom line. Some studies show that companies that have introduced consumer-directed health care options have had much lower cost increases for health insurance. If you're going to have a one-percent increase in your health insurance costs as opposed to a 12-percent

increase, how can you not look at that? It has to be an option that companies explore.

Boos-Allen-Hamilton believes that we are on the cusp of a real revolution in the way we finance health care in this country, and health savings accounts are the seed of that change. This is real money that you're spending on health care—the same kind of dollars you're spending at the grocery store or sending off to the mortgage company. If you want to be more involved in how that money is spent, to get better value for the care, that benefit can also accrue to you.

You can equate discretionary health spending to airfares. If you're willing to buy your airplane ticket three or four weeks in advance, and if you're willing to sit in the back of the plane and have limitations on when you go, you get a cheaper ticket. People don't complain about that; it's still the same safe airplane as first class, but they're paying less because they're willing to jump through a few hoops to save money. I think that people will be willing to do some of the same things with some of their health care purchases. Maybe they get their MRIs on Sunday mornings at 6 a.m. instead of Saturday morning at 10. They're still the same MRIs, the same quality care, but maybe at lower prices.

People say, however, that this is not where the high costs in our health care system are. That end-of-life and chronic care is where the real expenses are. And that is true. But unless we start with a different system and a new set of incentives for people who can take charge of health care decisions, we will never be able to build a new system that helps those with chronic illnesses—those who are shuttled from doctor to doctor, with duplicate prescriptions and tests—to get better coordinated, more efficiently-provided care.

### **A Few Simple Steps**

So what are we going to do about this? Just two or three simple things will help us set the foundation for a 21<sup>st</sup> century health care system. One of the nice things about market forces is you don't have to do much. If you want to develop a whole new health care system, you have to create

commissions and boards and mandates and penalties and provisions, and you have to write every rule. But with the free market, you send a few new incentives out there, and the market takes over and provides all sorts of new opportunities.

One of the main things we need is to equalize the tax treatment of health insurance so that if I buy health insurance from my employer, or if I buy it on my own, I get the same tax break. Right now, if I buy it on my own, I generally have to use after-tax dollars. If my employer purchases the policy, it's with pre-tax dollars. That doesn't give people very much choice. With the uninsured, or people who can't afford to pay that \$11,500 in health insurance costs, we can offer tax subsidies so that they can have real money to be able to purchase health insurance. Let's give them an option to buy health insurance on their own and then give them some of the same tax benefits that people with job-based coverage get.

We also need new kinds of purchasing opportunities for people. They need to be able to buy health insurance through places other than their employers. A lot of the uninsured are very mobile, moving from job to job. One of the reasons they're uninsured is because they're between coverage—they've left a job with health insurance and have a waiting time before their new policy kicks in. Let's give them the opportunity to purchase health insurance from some institution in their lives that may be more stable—their church groups, labor unions, professional associations, trade groups, or agricultural co-ops—so they have insurance they can keep, even if they change jobs. And one of the policy ideas that a lot of politicians are looking at as a way to do that is to create competition among the states by allowing consumers to buy health insurance from any state. We all know that you can bank at Bank of America, you can bank at Wells Fargo, or you can bank at Citibank, whether you live in Virginia or Minnesota or Texas. But when it comes to health insurance, you are forced to buy a policy only from an insurance company that operates in your state. It's highly regulated in many states, and there's often not a lot of competition. If you could buy insurance from other states, then consumers

would force states to be more competitive in the insurance market.

Those are just a few simple ideas that I believe could help transform our health sector into a truly functional free-market that puts consumers at the center and could become a model for the world.

*Following her remarks, Grace-Marie Turner answered questions from the audience.*

**Pearlstein:** Let me ask the first question. The United States has the most expensive health care system in the world. Why is that so?

**Turner:** The United States does spend much more on health care as compared to other countries. Part of the reason is that we are the center of health care innovation. That doesn't mean that there aren't smart scientists and innovative companies around the world, but this country is the epicenter of capital expenditures on medical innovation. European health care experts tell me, "Please, please don't stop, don't put price controls on your drugs, don't stop medical innovation, because we rely on you for this innovation." We're paying for a lot of the innovation that other countries are taking advantage of, and if we were not doing that, we could spend less on health care—and we also could ration care and force patients to wait for a year or more between a diagnosis and getting cancer treatment, as in other countries that limit people's access to new medicines and new treatments. You certainly see it in Canada. We could make health care cheaper, but right now, we're paying more for a better health care system that's more accessible and that's much more innovative.

**Tammy Lee:** You mentioned that health care is going to be one of the pressing concerns for the next Congress. Do you think we have a shot at moving something like association health plans through Congress?

**Turner:** Association health plans would allow organizations like the National Federation of Independent Business and the Chamber of Commerce to sell health insurance on a multi-state basis and with fewer mandates and rules.

Getting it enacted is tough. It has passed several times in the House, but the Senate has been the roadblock. They basically have to get 60 votes in order to get it through, and there are more than 40 senators who block it every time, including some who don't believe that there should be any free market consumerism, private competition, or for-profit motive in the health sector.

**Rachelle Kotrba:** I work at the University of St. Thomas, at the National Institute of Health Policy. If you take the money that the government is essentially losing from tax revenue because of how HSAs are structured and spend it towards universal coverage, you could cover all of our uninsured. Isn't that what we should be doing?

**Turner:** There are a lot of people who feel that if we could just distribute the money better that's already in our health care system, we would be able to cover the uninsured. I think you may have two tax policies in that question. When Congress passed the HSA legislation, it assumed that the revenue loss from people protecting money by putting it into HSAs would be only about \$6 billion *over ten years*, which is a drop in the bucket in dealing with the uninsured. But there is another provision, and that is tax forgiveness for any amount of money that your employer is willing to spend on your health insurance. That subsidization of job-based insurance amounts to about \$200 billion *a year*. The tax commission that just recently issued its report recommended we just disallow people from deducting more than \$11,500 a year in health insurance costs. Anything over that, you can still get a more expensive health insurance policy, but you're going to have to pay taxes on it. Then we could use some of those revenues to provide more resources to help cover the uninsured. But it takes, the most recent estimates say, at least \$100 billion a year to begin to make a dent in the number of people who are uninsured. So health savings accounts really are a very small piece of that puzzle. Covering the uninsured requires a much bigger, and more expensive solution.

**Albert Trostel:** Many people have severely criticized our system for being employment-based. If you agree with that assessment, what

steps should we take in order to move away from employment-based health care?

**Turner:** That's a really good question. I'm criticized in Washington by some big companies and associations because I believe we need to move and evolve to a system of more individual-based ownership of health insurance. When you see the job mobility in this country, and you see the opportunities for people to use technology to start and create their own businesses, tying health insurance to the job just doesn't work anymore for millions of people. The way we provide subsidies for private health insurance by tying them to the workplace is based on an industrial-age paradigm where you went to work in a factory and worked there until you retired and kept your company health insurance policy the whole time. It doesn't work that way anymore in an economy where, on average, four out of 10 people change jobs every year.

I think the fundamental thing we need is tax fairness. We're not going to pull employment-based health insurance out by its roots, but we need to create a parallel system and give people the same tax breaks to purchase their health insurance on their own as they currently get if they get their health insurance at work. It would help to have more price visibility, and this would force the health sector to provide more user-friendly and more affordable options for people. I think that's a really important step. As boring as it is, tax policy is the key.

**Dennis Sellke:** How do you entice unions who are negotiating health care into this kind of program?

**Turner:** I think this is a consumer-education project. It's a pocketbook issue. If people can see that they can begin to save money, and if they can begin to get more control over their health care decisions and health care costs, then they will start to ask for these products. That's what we see. It's really an education issue, and I think demand is going to percolate from the bottom up. As more people start to hear about HSAs and see their neighbors have money in theirs, they'll ask, "Why can't I do that? Why can't I have some of

the money that is going off to the insurance company?”

**Doug Larson:** What if a significant amount builds up in the savings account and accidental death occurs? Do the heirs inherit that, and does that go directly to that heir’s health savings account?

**Turner:** Actually, the HSA legislation addresses that: It becomes part of your estate and can be willed. It’s treated like other cash accounts in your estate, and heirs would have to pay taxes on it. That’s one of the attractions of a health savings account—it really becomes part of your net assets, your net worth. If there were a surviving spouse, the spouse could assume ownership of that HSA directly, without paying the taxes.

**Priscilla Frank:** What are we doing in our country to educate mid-level providers and doctors to be engaged in this? How do they view this movement?

**Turner:** It’s really all over the map. Some enlightened physicians totally get it, that this is all about getting back to a system where doctors and patients are in charge, rather than some outside bureaucrat. But a lot of physicians are so angry at the current system, and they’ve been so abused by it, that they don’t trust this new opportunity. The current president of the American Medical Association is very hostile to anything that’s consumer-directed, but AMA policy is very supportive. So the AMA is split, which I think represents the fact that the medical profession is still trying to figure out whether this new world is going to be better or worse than the current state of affairs. We actually see some doctors starting cash-only practices; they find they can reduce their rates and actually spend much more of their time treating patients rather than fighting paperwork. ■



1024 Plymouth Building  
12 South 6th Street  
Minneapolis, MN 55402

612-338-3605  
612-338-3621 (fax)

[AmericanExperiment.org](http://AmericanExperiment.org)  
[IntellectualTakeout.com](http://IntellectualTakeout.com)  
[Info@AmericanExperiment.org](mailto:Info@AmericanExperiment.org)