

DEFINED CONTRIBUTION: FROM MANAGED CARE TO PATIENT-MANAGED CARE

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After more than a decade of extraordinary turbulence in the financing and delivery of health care, it is sobering but probably accurate to anticipate even greater challenges in the near future. Indeed, one commentator has ventured that health care is heading for its own “perfect storm” (Miller 2001). After years of increasingly desperate attempts to centralize control over medical decisions and dollars, the next phase may take us “forward into the past” in ways that will finally reunite patients with their own health, health care, and health care dollars.

A bit of history will suggest how this is likely to play out. Lavish health care funding beginning in the mid-1960s led to decades of unrestrained spending, followed by desperate but unsuccessful attempts to contain costs. In the 1990s managed care introduced business concepts hitherto largely alien to the world of health care. The result was a much-needed taming of expenditures, but at the price of denials, delays, and inconveniences that sometimes were medically, personally, politically, and even economically counterproductive. Although health care clearly needed business discipline, many of the tools of managed care came from people who had considerable experience with businesses such as insurance, but relatively little experience with the clinical nuances of health care.

Managed care’s most notorious tactics quickly faded, partly via public backlash and partly as the late 1990s economic boom required employers to lure and keep good workers with generous health care benefits alongside hefty salaries. This phase, too, was short-lived, as the most recent economic slowdown now prompts yet another reexamination of the ways in which health care is financed and delivered.

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Promising changes are afoot, particularly via “defined contribution” plans that bring patients into closer contact with the costs of their care and thereby into greater control over the content of their care. This development provides an important opportunity to address important, longstanding flaws in the U.S. health care system.

History

U.S. health care has several fairly distinct eras that need only brief summaries here (Starr 1982, Butler and Haislmaier 1989). Prior to World War II, health care was not costly because physicians had relatively little to offer. It was the era of Modest Medicine. But during the wartime years of the 1940s and continuing throughout the post-war era, first-dollar insurance coverage became a standard benefit. Workers and their families came to expect that health care should never cost anything out of their own pockets. At the same time, several factors spurred a rise in health care costs that placed health care beyond the reach of most people’s pockets.

The 1965 enactment of Medicare and Medicaid brought large additional populations within the fold of the fully insured and, in the process, made standard some insurance practices that ensured ongoing price inflation. Retrospective fee-for-service (FFS) reimbursement paid for virtually any service rendered, as insurers were reluctant to challenge providers’ judgments about what care should be provided. At the same time, physicians and hospitals that were now paid according to “usual, customary, and reasonable” (UCR) fee schedules quickly discerned that health care could be very lucrative if they usually, customarily, and ever-so-reasonably charged very high fees (Roe 1981; Delbanco, Meyers, and Segal 1979). As private insurers quickly adopted the same reimbursement practices, health care came to be financed by an Artesian Well of Money in which physicians and patients could do virtually whatever they wanted, safe in the knowledge that money was no obstacle. Moreover, by deeming virtually any new drug, device, or procedure “medically necessary” and thus a covered benefit as soon as it received either government approval or physician acceptance, those insurance policies also fueled the furnaces of technology. Success ensured sales and profits for manufacturers, whose creativity in adding to the armamentarium of costly medical interventions became boundless.

The inflationary effects of such a system were inevitable and enormous. The 1970s and 1980s witnessed a host of efforts to contain costs, ranging from Nixon’s wage and price controls in the early 1970s, to legislation attempting to restrain the proliferation and un-

necessary duplication of costly technology, to the Carter administration's threat of mandatory price controls until hospitals agreed in 1979 to restrain their revenues voluntarily. In 1982 the federal government added DRGs—the diagnosis-related-group payment system in which hospitals are paid a flat sum for hospital care of a Medicare beneficiary, based on diagnosis and other factors such as gender, age, and co-morbidities. Instead of being rewarded for doing more, hospitals would now do better by doing less. Employers tried their own cost containment measures, such as increasing employees' copayments, encouraging healthier lifestyles, and requiring second opinions for surgeries.

These programs had little success and national health care expenditures continued to skyrocket. DRGs, for instance, helped to restrain hospital spending but left overall Medicare costs largely intact as hospitals simply shifted numerous inpatient procedures to the outpatient setting where they would be paid for on the usual FFS basis. The “Artesian” mentality still instructed physicians that it is unethical to consider costs over patient welfare (Morreim 1994: 81–82).¹

By the late 1980s, as international economic competition and a domestic recession forced widespread downsizing, employers determined that they no longer could absorb annual double-digit-percentage increases in health care costs. Particularly beginning on the West Coast, corporations gave health plans an ultimatum: limit premium prices or lose business. The Artesian era gave way to the Managed Care era.

The Entree of Business Approaches to Health Care

Prior to managed care, health plans were largely cost-plus, pass-through financiers who rarely denied payment (Havighurst 1986; Thurow 1984: 1570; Thurow 1985; Light 1983: 1316). But when corporate employers began to demand financial restraint, health plans were finally impelled to cut costs. The initial savings were not difficult to achieve. Hospitalization was a particularly easy target, as lengthy inpatient stays had become de rigueur. Once plans realized how many routine hospitalizations were not medically justified, their reductions

¹As Clark Havighurst (1986: 151) observes, “Although the medical profession's advocacy of quality in medical care without regard to cost appeared to reflect a sincere concern for patient welfare, it also served providers' economic interests. Not only did the suppression of normal economizing impulses pave the way for expansive and demand-increasing definitions of the need for providers' own services, but it also allowed providers to set their fees and charges on a noncompetitive and therefore highly lucrative basis.”

in hospital use generated substantial savings. Specialist services were also targeted because primary care physicians (PCPs) often charged considerably less and used fewer resources, even when treating the same conditions (Kassirer 1994; Azevedo 1995; Robinson and Casalino 1996: 9; Grumbach and Bodenheimer 1995; Gerber, Smith, and Ross 1994; Shea et al. 1992). Thus, gatekeeping systems required the patient's PCP to approve a specialist visit before the plan would cover the cost. Additionally, plans abandoned UCR payment in favor of fee scales and initiated a variety of other controls.

Initially, costs dropped significantly even while premiums remained relatively high, resulting in substantial profit margins. The larger a plan's market share, the higher its profitability, almost regardless of what sort of patient population the plan had. As a result, during the early- to mid-1990s, the health care industry witnessed an unprecedented round of mergers and acquisitions in which smaller plans were purchased by larger plans that, in turn, were purchased by still larger plans. Soon, premium prices leveled as well. Whereas 1990 premiums had risen by nearly 17 percent over the previous year, prices increased only about 1 percent in 1994. From then through 1997, annual health care inflation did not rise much above 2 percent (Wall Street Journal 2001).

The days of high profitability and merger-mania were short-lived, of course. Plans still had to keep premiums down even after the easy cost cuts were taken, and expensive new drugs and technologies steadily added to the costs of care. Additionally, plans found it increasingly difficult to enforce their overt denials of care in court, particularly in jurisdictions where "judge-made insurance" rulings consistently favored plaintiffs who claimed that they "reasonably expected" certain services to be covered (Abraham 1981: 1155; Anderson, Hall, and Steinberg 1993: 1636; Ferguson, Dubinsky, and Kirsch 1993: 2116; Morreim 2001).

Plans progressively tightened the screws. They restricted utilization further, trimmed provider fees ever tighter,² decreased inpatient stays to controversially short levels,³ and sometimes substituted

²The more dominant a given health plan was in a particular region, the more it could use its market share to extract fee reductions and other concessions from providers. In some cases physicians have responded to such monopsony buying power by joining unions or initiating lawsuits.

³For instance, many plans began to regard mastectomy as an outpatient procedure, and to regard 24 hours as the appropriate inpatient stay for normal childbirth. Public outcry became so vociferous that the federal government and many states enacted legislation mandating broader inpatient care for these conditions. See Johannes (1996), Hoffman (1999), and Korobkin (1999).

lesser-trained personnel for traditional providers (Anders 1995; Twedt 1996). To encourage physicians' adherence to utilization guidelines and gatekeeper systems, many plans added incentive arrangements that rewarded physicians for cost consciousness (Orentlicher 1996). Many plans transferred financial risk to physicians via capitation contracts that ranged from capitating only the physician's own professional services, to broader risk transfers in which the physician managed costs for lab tests and specialist services, to "full-risk" arrangements in which physicians, in essence, became a health plan by accepting the entire premium in exchange for providing the complete spectrum of care (Woolhandler and Himmelstein 1995, Ogrod 1997).

As more patients were denied care or coverage to which they thought they were entitled, "horror stories" proliferated in the media and even in the courts (Herdrich v. Pegram 1998, Andrews-Clarke v. Travelers Ins. Co. 1997, Larson 1996, Meyer and Murr 1994, Hilzenrath 1995, Anders 1996). While this essay does not aim to evaluate those claims, fairness requires closer examination. Whereas critics accused health plans of greed, the reality was not so simple. For years, corporate and government payers had implored providers to be more cost-conscious, yet costs continued to soar because the fundamental economic structures that produced unbridled inflation (cost-plus reimbursement policies and tax subsidies for first-dollar group health insurance) remained in place. Ultimately there was no alternative but to bring business discipline to health care.

However, just as the clinicians who knew the most about health care were often the least savvy about financial issues, conversely the people who knew most about business often had relatively little understanding of the clinical implications their cost cuts would actually have. Hence, one important factor behind many of ostensibly foolish denials and delays of care may have been these managers' lack of experience with the highly nuanced realm of health care, as distinct from the self-interested motives typically touted by critics (Morreim 1998).

Crossroads

By the late 1990s, negative press, contentious litigation, and threats (and sometimes realities) of restrictive legislation had eroded the effectiveness of major cost containment tools. At the same time, a booming economy tightened the labor market enough that firms

wanting to attract and keep good labor needed to ensure that benefits were generous and friendly.⁴

The health care market reacted swiftly. By 1999 one large HMO, United Healthcare, announced that it would forego traditional utilization review (UR) in favor of a broad profiling of its physicians' practice habits. Aetna, the nation's largest health insurer, echoed the move. Many health plans also dropped or reduced gatekeeping arrangements and other controls over medical practice (Dudley and Luft 2001). Around the same time, many plans also began to back away from the incentive systems that encouraged physicians toward cost-conscious treatment decisions. Although most courts declined to declare incentives to be inherently unlawful,⁵ negative press left them unpalatable (Terry 2001, Dudley and Luft 2001, Johnsson 1997). Other vehicles for cost containment, including reductions in providers' fees and controls over physicians' practice arrangements, likewise could only be pushed so far. One of the most substantial episodes of fee tightening, the Balanced Budget Act of 1997, trimmed Medicare fees for hospitals and physicians so tightly that a fairly extensive restoration of funds was needed several years later.

At about the same time these cost containment devices wound down, several factors began to push costs upward. During the mid-1990s, premiums had been so low that many plans' incomes simply did not keep pace with costs. By the end of the decade, they needed to recoup those losses in order to prove to Wall Street that they were still capable of being profitable (Kuttner 1999). Plans also needed to improve their fee scales to retain adequate numbers and quality of physicians and hospitals during the economic boom of the late 1990s. And expensive new technologies continued to enter the market. Drug costs, for instance, rose markedly (Zimmerman 2000; Pear 2001a, 2001b). All this forced premiums to rise once again. Whereas health care inflation in 1997 was only 0.2 percent, the next year the figure rose to 6 percent, and it continued to rise thereafter (Blumenthal 2001).

More recently, broader economic forces push in the other direction. As the economy slowed down in 2001, firms became considerably less eager to pay the kind of premium hikes that health plans need if they are to maintain quality, add new technologies, and still

⁴In essence, "Employers seem to have lost their teeth entirely. . . . They are so constrained by tight labor markets they don't want to be aggressive with plans or employees" (Winslow and McGinley 2001, quoting Paul Ginsburg of the Center for Studying Health System Change; see also Blumenthal 2001).

⁵See especially *Pegram v. Herdrich*, 530 U.S. 211 (2000).

remain solvent. Smaller firms are especially pressed between the unsavory options of cutting back on benefits, increasing employees' share of the cost, or even eliminating health benefits altogether.

The result is another crossroads for health care. Everything points to higher costs. Easy cost cuts are long gone. The major cost-cutting tools—UR, incentives, and provider fee concessions—are largely played out. The hefty profits that fueled merger-mania are long gone. Costly new technologies emerge steadily, and patients, sometimes backed by courts, continue to demand them. But employers have no interest in diving back into the Artesian Wells of the past. Although challenging and difficult in many ways, this latest crossroads may finally make it possible to resolve a problem that has affected the nation's health care systems for many years.

The Next Stage

As the nation moved from the Artesian era to the Managed Care era, many commentators realized that the financial incentives guiding various participants were sometimes in sharp opposition. The early days of Medicare DRGs, for instance, encouraged hospitals to discharge patients as quickly and efficiently as possible, since they would receive the same payment no matter how long patients lingered or how many services they received. At the same time, physicians were still paid fee-for-service for those same patients' care, hence they were still rewarded for keeping patients hospitalized as long as possible and performing as many interventions as possible. The better hospitals did, the worse physicians fared, and vice versa.

Numerous instances of such discrepancies precipitated efforts to "align" the incentives of all the major players in health care financing and delivery, using incentive systems, integrated networks, and other tools to synchronize the interests of physicians, hospitals, clinics, insurers, health plans, administrators, employers, and governments. Unfortunately, all this aligning usually neglected one crucial party. Patients' incentives were being lost in the shuffle. In all the discussions about matching up the interests of the major players, there was little if any suggestion that patients are among the players to be aligned (Sederer 1994: 367; Sulmasy 1995; Rogers, Snyderman, and Rogers 1994: 1376; Hall 1994: 34).

The justification for leaving patients out has two aspects. The first argues that patients should not have to bear or even worry about the costs of their care when they are ill. Medicine is very expensive, after all, and most people can afford little of it on their own. Financial barriers can keep patients from receiving needed care, potentially

exacerbating long-term morbidity and mortality. Moreover, ill people are often less capable of normal deliberation as consumers.

The second, corollary argument is that, so long as patients do not significantly experience the cost of their care, they really cannot be trusted to decide which care is cost-worthy. Patients who don't really appreciate the cost of their care are ill equipped to decide which care is worth buying. The problem is exacerbated where patients' copays are very small, as in many HMOs. A \$5 or \$10 copay for an office visit may eliminate financial barriers to care, but equally it may ensure that patients pay little heed to costs or to the wisdom of their resource use. In that context many patients tend to adopt an entitlement mentality that they ought to receive whatever they want because, after all, they have already paid for it by purchasing the plan in the first place.

The conclusion is thus drawn that patients should not be expected, and because of such benevolent economic insulation they should not be allowed, to decide which sorts of care are worth buying. Patients are thereby trapped in a Catch-22, relegated to being passive recipients of others' decisions about the sorts of care they ought to be permitted to have.

Patients need not be excluded in this way. As discussed below, they can be provided with incentives that foster economic prudence, yet do not create undue financial barriers to care. More interestingly, the crossroads described above—in which traditional cost containment tools are losing potency while new upward pressures threaten to make health care costs skyrocket once again—presents a remarkable opportunity to bring patients back into decision making. That opportunity may come via a fundamental change in the way that the employers and governments who purchase health care conceive of their objective. The shift is only beginning to occur but it is probably inevitable and, properly implemented, highly desirable.

Defined Contribution

Basic Concepts

Fundamental change ahead involves a shift from “defined benefits” to “defined contribution.” Under the traditional defined benefits approach, an institutional purchaser such as an employer determines what range of services it will cover, then seeks or creates a plan that will provide those services for an acceptable price. It has become

increasingly difficult to sustain a defined benefit system. A steady stream of emerging technologies requires an equally steady stream of decisions about which ones will be covered by the plan. Moreover, it has become nearly impossible to provide such benefits economically, in the face of rising health care inflation and increasingly impotent cost-cutting tools.

In contrast, under defined contribution, the employer determines up front how much it will spend for health care, then typically provides an array of options from which beneficiaries can choose (Wye River Group on Healthcare et al., Parrish 2001, Blumenthal 2001). Those options can assume various forms. In the oldest, most familiar version, the contribution essentially represents a voucher for a conventional health plan. The employer assembles a collection of plans from which employees can choose, and then defines its own contribution according to the least expensive of those plans. The Federal Employees Health Benefits Program (FEHBP) is a leading example. In the FEHBP, the federal government screens plans to ensure they cover an adequate range of services, but employees then are free to choose whichever plan they want, paying the difference for costlier plans out of pocket. In the private sector, corporations and purchasing pools have developed similar programs (American College of Physicians 1996; Schauffler, Brown, and Milstein 1999).

Newer versions of defined contribution, commonly implemented as “consumer-directed healthcare benefits,” feature financial accounts on which the beneficiary can draw. The account might be a Flexible Spending Account (FSA) in which employees set aside their own pre-tax money to cover expenses of designated sorts, including health care. Or it can be a Personal Health Account (PHA) that an employer funds, or some combination of the two (Wye River Group on Healthcare et al. 2001, Robinson 2001, Parrish 2001).

Within this spending account approach, employees can simply purchase a conventional health plan or, in more interesting versions, buy individual services and products or use the funds to cobble together a health plan to suit one’s preferences. One basic approach is modeled after the medical savings account: the employee uses some of the funds to purchase a high-deductible insurance plan, then draws on the remainder to pay for individual expenses that arise throughout the year, ideally with the freedom to roll over any funds left from one year into future years. The spending account might be sufficient to cover the entire deductible, or it might require the employee to ante up some expenses out of pocket.

The variations on this theme are endless. Employers might, for instance, deposit an employee’s defined contribution with an Inter-

net-based health plan.⁶ These plans provide an array of services. For instance, many provide lists of providers along with their fees, education, credentials, and perhaps consumer satisfaction ratings. Such a plan might then invite the enrollee to assemble his own provider panel based on price, copay expectations, and other considerations. In other cases the plan might indicate what payment it will provide for a given service, enabling the enrollee to choose whatever provider he wants and pay out of pocket any difference between the plan's allowance and the provider's fee. Such a plan might also permit the enrollee to establish a special account to cover routine services and preventive care, and perhaps set up other sub-accounts to cover designated medical procedures such as carpal tunnel repair or knee arthroscopy. In a less complex version, a web site simply offers information about providers willing to accept deeply discounted fees in exchange for direct cash payment.⁷ Plans may also offer online or phone-based health counselors to assist in decisions about which health services to seek.

Typically such Internet-based plans also help enrollees keep track of expenditures as they draw on their spending account for various services and plan for future needs.⁸ In some plans money not used during one year can be rolled over for use in future years, although the exact details depend on funding sources and applicable tax rules. In cases where the enrollee spends all the money in his spending account and still needs care, or where he uses out-of-area services, traditional insurance coverage takes over. That coverage might begin immediately or the enrollee might be required to spend some of his own money as a "bridge" before catastrophic insurance coverage begins.

In sum, self-directed plans permit the enrollee to become his own benefits manager and utilization reviewer, deciding which services are worth purchasing at what price from whom, and managing the money in his account to promote prudent purchasing of the health care he values.

For employers, the obvious advantage of defined contribution is the ability to limit expenditures at the outset, rather than promising a

⁶See, e.g., HealthMarket, at www.healthmarket.com; Lumenos, at www.lumenos.com; Vivius, at www.vivius.com; Definity Health, at www.definityhealth.com; Myhealthbank, at www.myhealthbank.com; HealthAllies, at www.healthallies.com.

⁷See SimpleCare, at www.simplecare.com.

⁸The spending accounts have been called, variously, Health Savings Accounts, Personal Care Accounts, Health Care Purchasing Accounts, and Health Freedom Accounts, among other terms.

level of benefits and then hoping to find an affordable price. At the same time, beneficiaries face an obvious potential disadvantage. Because the employer no longer accepts increased costs to support a given level of care, beneficiaries may end up with whatever lesser level of care the defined sum will buy. However, that downside is hardly the final analysis. For one thing, even defined benefits plans do not actually assure a given level of benefits. Worsening economic conditions have prompted many employers to make marked cuts from one year to the next. Even within a given year, enrollees cannot be sure that their benefit levels actually remain intact. So long as health care contracts provide only vague promises to cover “medically necessary” services, health plans can steadily erode the actual level of coverage within any given plan simply by declaring this or that service to be unnecessary. On the other hand, the advantages of defined contribution—particularly the spending-account versions—can be substantial.

Advantages

First, where patients pay for the daily, mundane health care expenses out of a dedicated account, they face no significant financial barriers to care. Assuming that the dedicated health account is sufficient to cover most routine expenses plus purchase a catastrophic plan, even an otherwise impecunious patient need not forego ordinary care on account of cost. Reciprocally, patients themselves enjoy the financial savings of prudent purchasing. In conventional plans, when coverage for a service is refused as “unnecessary,” it is plans, employers, or governments, not patients, who pocket the savings.

Second, the patient has virtually complete control over which services he receives, at least for routine expenses covered directly by the personal savings account. There is no need for an HMO or other health plan to dictate which tests, treatments, and drugs the patient may receive, or to deny coverage for nonstandard services such as acupuncture or laser vision correction, because the patient covers these directly from his own account. Self-control replaces external control.

Admittedly, MCOs’ control over specific health benefits has loosened in recent years. And yet that loosening has come at the cost of substantial premium increases that employers are unlikely to shoulder for long during an economic downturn. If so, then MCOs wanting to stay in business will be forced to reinstate significant control over medical/spending decisions, to place pervasive monetary caps on various kinds of services, or to find some other way to clamp down once

again on the rising costs of care. If costs must be contained, and patients are not incentivized to do it for themselves, someone will do it for them.

Third, the patient likewise controls which providers he sees because the patient, not the plan, directly incurs the expense. He can choose any physician or specialist, any time he wishes, without begging for gatekeeper approval. More important, the patient is free to continue in a physician-patient relationship he likes. One of the more egregious flaws of mid-1990s managed care was frequent changes in provider networks. Sometimes they occurred when employers shifted employees to a new health plan with a different provider network, and other times when health plans discontinued contracts with particular providers or provider groups. Either way, many patients and physicians were deeply distressed by being forced to sever longstanding relationships simply because this year's plan had changed. Such disruptions can be medically and economically counterproductive. Studies show that continuity of relationships yields better outcomes, lower costs, and greater satisfaction for patients and physicians alike (Barr 1995, Ferber 1996, Roulidis and Schulman 1994, Epstein 1995).

Health plans, too, can benefit when patients remain with a particular plan over time. When patients frequently shift from one plan to the next, plans that provide excellent care for chronic diseases such as diabetes can suffer significant financial losses because, years hence, some other plan will enjoy the financial rewards of this plan's forward-looking preventive care. However, once patients have the power to choose their own health plan, including to choose the same plan from one year to the next, plans have an incentive to please the patient rather than the employer, and to attract that patient's continued business. Ultimately, such relationships might even make multiyear contracts possible, thereby enhancing plans' ability to improve service and control costs over the long range.

Fourth, once the patient is financially free to contract directly with the physician of his choice to buy the services he wants, the physician-patient relationship can be on a sounder ethical footing than in many MCOs. Physicians need not labor under odious external micromanagement, nor spend endless hours begging and haranguing permission to provide the simplest interventions. Neither do health plans need to pay physicians insidious incentives for withholding care. In the routine care covered by a spending account, the only financial relationship is between the physician who recommends an intervention and the patient who receives and directly pays for it. If the physician says, "you don't need the costly brand-name drug," the

patient need not wonder about ulterior motives. And if the physician says, “you really do need this test,” the patient knows the only incentive is the traditional FFS incentive encouraging physicians to do more than is needed. However, where the physician knows that any excess comes from the patient’s own account, and not from a rich, distant insurance company, the professional ethics of personal fidelity are far more likely to shape his recommendations. Moreover, patients who are spending from their own account are more likely to ask whether something is really needed, whether it can wait, or whether there is a more conservative alternative.

Fifth, opportunities for fraud are greatly reduced. When third parties cover the expenses and the bills are breathtakingly complex, patients have little reason to scrutinize bills to ensure every entry is correct. Indeed, third-party payment encourages providers to continue their inscrutable billing practices, so that errors are not readily noticeable. In contrast, where patients pay their own bills immediately after services, they know whose financial account is being drained and they know (or can immediately ask) whether they are being properly charged. Moreover, even providers who might be inclined to cheat a large, anonymous insurer may be much more reluctant to defraud a patient with whom they have a personal relationship.

Sixth, spending accounts can yield administrative cost savings. When patients are empowered to make their own decisions, there is no need for costly claims-processing procedures, eligibility determinations, utilization review, or appeals following denials of coverage. Patients can simply present a debit card to the physician, pharmacist, or whomever, and payment is instant. In the process, providers need not wait weeks to months, nor file multiple claims, before they are paid.

Seventh, patients who want extravagant or nonstandard care are not imposing on other people, at least within the ambit of the spending account. If the patient wants the costliest drugs, he pays out of his own funds, not common resources. At the same time, the fact that the patient pays means that most decisions will be considered more carefully than they are at present. It is easy to demand antibiotics for a viral illness or insist on the expensive new drug advertised on the television when others bear the costs. It is another thing when the cost of that drug comes directly out of one’s own funds. By the same token, with more prudent decision making it may even be possible to avoid some of the problems of medical excess, such as the emergence of resistant organisms resulting from overuse of antibiotics.

Eighth, when health plans no longer need to govern myriad small

expenses they are free to focus on the important realm: costly care for people with serious illness or injury, i.e., the people who dip into their catastrophic coverage. As of 1996, 1 percent of patients consumed 27 percent of total health expenditures, while the top 10 percent of patients consumed nearly 70 percent, and the top 30 percent consumed 90 percent. This picture has not changed significantly over several decades (Berk and Monheit 2001: 12). Plans need to stop niggling over minor matters and take the lead in assessing costly new technologies and innovative interventions, to ensure that evidence-based approaches will make the best possible uses of the great majority of common funds.

Ninth, defined contribution approaches are considerably more portable than many current health plans. Particularly where self-insured employers establish their own distinctive set of benefits and provider networks, workers who change jobs usually begin a completely new plan, often with new providers. In contrast, because large-deductible catastrophic plans generally permit enrollees to choose their own providers and treatments, at least at the lower levels within the deductible range, they offer considerably more continuity across job changes.

Finally, patients who control their own dollars have considerably greater reason to be informed participants in their own care. When employers choose the health plan, and when plans determine which care is “necessary” from what kind of provider in which setting, patients have relatively little reason or opportunity to become full partners in their care. Active participation in one’s care can, in itself, be medically salutary (Kaplan et al. 1996; Kaplan, Greenfield, and Ware 1989).

Admittedly patients can make mistakes, such as to forego useful care in order to save money. However, it is not clear that patients’ decisions about which care is (un)necessary will be any worse than the denials now issued by health plans, often for medically dubious reasons. Moreover, it is not always so clear when a given intervention is actually useful; let alone “necessary.” The science behind the guidelines and recommendations issued by plans and by providers is often scanty in both quality and quantity, and one day’s gospel becomes the next day’s heresy with surprising facility. For another thing, when patients are restored to a mutually trusting relationship with their physicians, they may be more amenable to persuasion about which care is most important and thereby worthy of dipping into their medical spending account. Also, because defined contribution funds can be dedicated to health care and made immediately available, patients have far less reason to forego important care than in standard plans

requiring patients to pay deductibles out of pocket for first-dollar health expenses.

In the final analysis, the past decade's extraordinary turbulence has taught some important lessons. It has been a time of trial and error in which the medical community's failure to constrain its spending gave way to a business orientation that failed to appreciate clinical realities. Doctors did not make good business people and business people did not make good doctors. Still, the transition is hardly complete and we may yet see a happier ending. The time has arrived to integrate patients into the picture and restore to them the power and responsibility of the purse that can, in turn, permit them the freedom to shape their care according to their own values.

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