

Consumer-Directed Doctoring: The Doctor Is In, Even If Insurance Is Out

Statement of

Robert A. Berenson, M.D.

Senior Fellow, Health Policy Center
The Urban Institute

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Mr. Chairman, Mr. Stark, and distinguished members of the Committee: Thank you for inviting me to share my views on the growing phenomenon of physicians providing care outside of insurance. This is a timely hearing and I hope to bring a different perspective to the Committee's consideration of the crucial role of health insurance in protecting Americans' health and financial well-being. The views I express are mine alone and should not be attributed to the Urban Institute or any of its sponsors.

In the March/April 2004 issue of *Health Affairs*, colleagues from the Center for Studying Health System Change and I published an article titled "Financial Pressures Spur Physician Entrepreneurialism," which was based upon dozens of interviews we made with physicians and others in 12 metropolitan areas as part of the ongoing Community Tracking Study.¹ The study documented that physicians are experiencing pressures on their practices from a combination of factors, including reduced reimbursement rates, increased overhead costs, and higher premiums for liability insurance. It is not surprising, therefore, that physicians are looking for alternative revenue sources beyond what they earn for insured services. Unfortunately, we concluded that physicians' business practices are actually contributing to rising service use and, as a result, hindering cost containment efforts, the combination of which could exacerbate current problems with access to services for the uninsured and underinsured.

A particular problem we identified was the continued spread of physician investments in ancillary services and, as the ultimate manifestation of entrepreneurialism, the ownership of specialty facilities to which physicians refer their patients. We found that concierge care and similar approaches that permit and encourage patients to obtain services outside of insurance were not yet widespread. In the communities we researched, at most a handful of physicians were engaged in this form of boutique medicine. More recently, there has been a new development of "pay-as-you-go," cash-only medical care –

¹ Pham, Hongmai H., Kelly J. Devers, Jessica H. May, and Robert Berenson, "Financial Pressures Spur Physician Entrepreneurialism," *Health Affairs*, Vol. 23(2), 2004.

purportedly a lower cost alternative for patients without good health insurance, a possibly new approach which is being presented at this hearing

Some Physician Frustrations with Insurance Are Well-Founded

As physicians grow frustrated with the rising administrative costs and complexity of running a practice, the hassles associated with network contracting, and payment systems that have not kept up with the changing nature of medical practice, many believe that the health care system and the doctor-patient relationship would be better off if more care were provided outside of insurance, which would be reserved only for catastrophic expenses. The frustrations are real, as are the problems that produce them. Some responses, including those being discussed at this hearing, I believe, are meant to improve physicians' ability to provide care and to provide an alternative for patients who face escalating health insurance premiums and increasing cost-sharing as part of their insurance packages. These physicians understandably have an impulse to get out from under the rules and regulations associated with public and private insurance and to have more control over their own working conditions.

While these physician-initiated alternatives to the standard insurance-based systems may have some limited application, I think they represent symptoms of a system lacking universal, comprehensive health care insurance. Again, the oft-quoted H.L. Mencken line is applies, "There is always an easy solution to every human problem – neat, plausible, and wrong."

Clearly, there is a market for affluent patients and an elite tier of mostly primary care physicians supplementing the regular system of care based, necessarily, in comprehensive health insurance. However, the market receptivity of those able to afford concierge care and other, less dramatic approaches to providing "subscription services," e.g., communication via e-mail as an alternative to office visits, suggests that public and private payers can and should reform their payment approaches. Similarly, individuals and small employers, in particular, face exorbitant administrative costs that divert crucial

dollars from patient care.² Of course, physicians object to the gross inefficiencies and patient indignities associated with the individual and small-group insurance markets.

There are numerous lessons in these physician-sponsored initiatives that offer the possibility for major improvement in the operation of health insurance, private and public. For example, within insured products, we can be more creative in the use of tiered cost-sharing, modeled on triple-tiered pricing for prescription drugs, to try to influence patient behavior and have the patient bear more of the costs of truly extravagant choices. Similarly, those who provide concierge care maintain that having sufficient time to conscientiously attend to patients' concerns and needs forestalls expensive specialty care that time-pressured primary care physicians resort to. Based on my experience practicing general internal medicine for over twenty years, I concur that current fee-for-service reimbursement methods emphasize quick, face-to-face physician-patient encounters, while discouraging other important activities, such as reviewing records, coordinating care with other professionals, and communicating by telephone and e-mail.³

Yet, at its best, providing substantial health care services for much of the population outside of insurance is an elitist notion. It perhaps has a role for those affluent individuals willing to pay out of their own pocket, not subsidized by taxpayers, for special attention that a few physicians, frustrated with the rules imposed by insurance programs, want to offer. I do not criticize those who provide concierge care, although it is unfortunate that these physicians have felt the need to opt out.

Medical Care Has Unique Attributes that Do Not Conform to Normal Markets

For many reasons, these cash-based, extra-insurance models do not deserve broad application as a substitute for comprehensive health insurance. All developed countries

² Blumberg, Linda J. and Len M. Nichols. 2004. "Why Are So Many Americans Uninsured?" *Health Policy and the Uninsured*, Catherine G. McLaughlin, ed. Washington, DC: Urban Institute Press.

³ Larson, Eric B., for the Society of General Internal Medicine Task Force on the Domain of General Internal Medicine. "Health Care System Chaos Should Spur Innovation: Summary of a Report of the Society of General Internal Medicine Task Force on the Domain of General Internal Medicine," *Annals of Internal Medicine*, 140(8), 2004.

besides the United States are able to provide universal, comprehensive insurance coverage to their populations at levels of a half to two-thirds of what the United States spends, whether calculated as per capita spending or as a percentage of the gross domestic product. These countries accomplish this either through social health insurance programs or national health systems that face similar theoretical problems associated with the moral hazard of third-party, insurance payment. But only in the United States do we seriously discuss endorsing an approach that would parcel out health care by the ability of patients to pay.

Forty years ago, on the eve of passage of Medicare and Medicaid, Nobel laureate Kenneth Arrow turned his attention to how medical care differs from most other sectors of the economy in a landmark article that is as relevant today as then.⁴ Among the unique attributes of the medical care system, he pointed to the asymmetry of information possessed by buyers and sellers. “Because medical knowledge is so complicated, the information possessed by the physician as to the consequences and possibilities of treatment is necessarily very much greater than that of the patient, or at least so it is believed by both parties.”

Arrow further explained at length that uncertainty, that is, the reality that the need for medical care is irregular and unpredictable, characterizes the nature of the service the professional is giving. The buyer-patient depends upon the seller-physician for a trusting professional relationship to help address the inherent uncertainty that underlies much medical care. The pervasiveness of uncertainty and the asymmetry of information lead to a relationship of trust and confidence, which is not present in a pure, market-based relationship. Thus, he concludes, “Purely arms-length bargaining behavior would be incompatible, not logically, but surely psychologically, with the trust relationship.”

⁴ Arrow, Kenneth J., “Uncertainty and the Welfare Economics of Medical Care,” *The American Economic Review*, 53(5), 1963.

The Problems Presented by Health Savings Accounts

Some approaches you will hear about today actually assume the desirability of arms-length bargaining between patient and physician. To further their adoption, many now promote insurance products featuring high deductibles and only catastrophic insurance coverage, such as Health Savings Accounts (HSAs).

However, as I have followed the debate, I have found the logic of high deductible plans is usually supported by simplistic clinical examples that ignore the prevalence of uncertainty and information asymmetry that Arrow described. We often hear of the patient with a straight-forward clinical problem, such as an upper respiratory infection, who can avoid insurance, long waits and paper work by paying, say, \$50 directly to a doctor in a clinic. We do not hear about the patient with an upper respiratory infection who also is a diabetic on insulin and has renal failure and hypertension. For such a patient, the \$50 cash payment might become hundreds of dollars for a proper evaluation, especially if carried out by a physician who does not know the patient and does not have the patient's medical records. Perhaps this approach would be less costly than care in a hospital emergency department, but the goal should be that every American has a primary care physician responsible for providing ongoing care and coordinating the care provided by specialist physicians and other providers.

Another typical example used to promote HSAs is the middle-aged, weekend tennis player with knee pain whose sports medicine orthopedist recommends an MRI scan of the knee. With a high deductible plan, the theory goes, the patient who now has to pay out of pocket might challenge the need for the MRI and would then search out a facility with lower prices. The decision to proceed would be made as other marketplace transactions are.

Now to the real world. A friend of mine, with good insurance, recently had knee pain. Only it did not interfere with his tennis game, but rather with his occupation – he is a carpenter, and the knee pain was interfering with his ability to work. On the

recommendation of the sports medicine orthopedist, he had an MRI. And unexpectedly it showed a “hole” in one of the bones around the knee. Although it was interpreted as likely to be a cyst, his physician wanted him to see an orthopedic oncologist to evaluate the radiological finding. That physician concurred that it most likely was a benign cyst but strongly recommended a follow-up MRI scan six months later to make sure there was no change. The concern here was the slight chance that the abnormality represented cancer.

As it turned out, the abnormality proved benign. Two expensive MRIs were performed, and they were performed based on expert clinical judgment and at facilities selected by the physicians. Expecting patients to become not only marketplace consumers but, in effect, clinicians able to grapple with scientific uncertainty and to gamble with their own health, in this case, with the specter of cancer, is inappropriate and unfair. Again, there may be some role in insurance products for applying variable patient cost-sharing to try to influence patient decisions, perhaps to select higher quality and more efficient professionals and providers. But expecting patients to make important medical decisions without the fundamental financial protection provided by health insurance is not in the best interest of patients, physicians, or the public.

At a practical level, moving the system to large deductible plans with pure catastrophic coverage, the Health Savings Account model, would disrupt insurance markets and would not likely reduce health care spending enough to be worth the threat that this approach represents.

First, it is likely that relatively healthy, affluent individuals would be the group most likely to opt out of comprehensive insurance products, leading to high insurance costs for those whose health problems give them no choice but to remain in the basic health insurance pool. As healthier families and individuals opt out of traditional insurance coverage, those remaining in comprehensive health plans would be more expensive to insure. This will lead to destructive market segmentation, driving up premiums for traditional coverage even further and setting off a spiral of adverse selection. The

comprehensive health insurance option would become unaffordable precisely for those who need its protection.

Second, most of the costs that drive inflationary health care spending are associated with a small percentage of patients who have very large health expenditures. In most health insurance systems, private and public, with minor variations, about 5 percent of patients are responsible for about half of the expenditures. Because most health spending is attributable to the small share of individuals with very large medical expenses, increasing deductibles far above current levels will not result in much savings, even if care-seeking behavior for those with the deductibles changes marginally. Although some physicians might reasonably believe that high-deductible plans were changing patient desire to have certain discretionary services, for the system as a whole, the cost containing potential of HSAs would be illusory.

Third, by requiring individuals to pay for medical expenses up to the high-deductible amounts, starting at \$1,000 for single and \$2,000 for family policies, high-deductible insurance would surely discourage low- and moderate-income individuals and families from receiving preventive care and the early diagnosis and treatment needed to head off costly illnesses and complications. With all the progress made in medicine, medical care is still based on substantial clinical uncertainty, an asymmetry of information and the need for a physician-patient relationship rooted in trust. Patients correctly are risk-averse and unreasonable financial barriers to care will surely lead to adverse health consequences.

Health Care Markets Remain Unique

We can agree that forty years after Arrow's commentary things have changed in a number of ways. We now have the Internet, where some patients can gain information about details of diagnosis and treatment that even expert physicians do not immediately know. However, even with this information aide, medicine has become that much more

complex. Asymmetry of information between the seller and the buyer has not diminished. And in many ways the clinical stakes are higher.

Since 1963, we have accepted that patients should not be passive, merely accepting a paternalistic physician's diagnosis and treatment recommendations. Patient preferences for alternative treatment options and their personal values on matters of life and death need to be respected and, often, deferred to. In the area of chronic care management, it has been shown that patients can improve their own health and well-being by becoming better educated and motivated to take responsibility for directing important aspects of their own care. However, we should not confuse activating patients to take greater control over their own care with turning them into consumers able to engage the health care system as if they were buying an airline ticket on the Internet.

And physicians need to remember they are professionals, one of whose important precepts is that they should be acting in the best interests of their patients. In the *Health Affairs* article referenced earlier, we expressed the concern that, in the era of managed care, physicians sometimes felt they compromised their professional agency relationship with patients by becoming, in effect, "double agents," with potentially conflicting responsibilities to patients and the insurance companies with which they did business. We then wrote, "In the post-managed care era, physicians have responded to mounting financial pressures with a range and intensity of activities that evoke images of 'free agents' defending their own financial interests and challenging established professional norms."⁵ Although the activities described in this hearing do respond to real problems spawned by practices of insurance companies, I remain concerned that the responses presented by the other physicians at this hearing would, if broadly implemented, threaten the important role of public and private insurance and further compromise the physician-patient relationship.

⁵ Pham, *Health Affairs*.