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### *Consumer Driven Healthcare: Does it Increase Access for the Poor, Uneducated, and Chronically Ill?*

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#### I. INTRODUCTION

The current healthcare system needs reforming. Over forty seven million Americans are currently uninsured<sup>1</sup> and need reasonable access to healthcare. The current system is a “private-market employment-based system” that has high costs and inherent barriers for access to healthcare.<sup>2</sup> Consumer driven healthcare (CDHC) has recently been promoted as a way to reduce the high costs associated with the current system.<sup>3</sup> The ideal healthcare plan would reduce costs while providing more access to healthcare. The poor, uneducated, and chronically ill arguably need help accessing the healthcare system and are the most vulnerable.<sup>4</sup>

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<sup>1</sup> Arthur Birmingham LaFrance, *Healthcare Reform in the United States: The Role of the States*, 6 SEATTLE J. SOC. JUST. 199, 211 (2008).

<sup>2</sup> John V. Jacobi, *Consumer-Directed Health Care and the Chronically Ill*, 38 U. MICH. J.L. REFORM 531, 536 (2005).

<sup>3</sup> Linda M. Axtell-Thompson, *Consumer Directed Health Care: Ethical Limits to Choice and Responsibility*, 30 J. MED. & PHIL. 207, 208 (2005).

<sup>4</sup> See Walter L. Stiehm, *Poverty Law: Access to Healthcare and Barriers to the Poor*, QUINNIPIAC HEALTH L.J. 279, 279 (2001); Wendy K. Mariner, *Can Consumer Choice Plans*

This paper will focus on the concept of CDHC and whether it will improve access to healthcare for the poor, uneducated, and chronically ill.

## II. CONSUMER DRIVEN HEALTHCARE AND HEALTH SAVINGS ACCOUNTS

CDHC is a healthcare system that allows patients' greater control and responsibility over their medical services and healthcare spending in an attempt to control costs.<sup>5</sup> Under the consumer driven model, the patient is viewed as a consumer in the marketplace of health services.<sup>6</sup> Generally, patients have a personal health account, such as a health savings account (HSA), and an insurance plan with a high deductible.<sup>7</sup> The deductible is at least \$1050 for individuals and \$2100 for families.<sup>8</sup> Initially, patients pay for their medical care out of their HSAs. After the deductible amount has been met, health expenses are paid from the insurance plan<sup>9</sup> and the patient pays something similar to a co-pay.<sup>10</sup> Once an out-of-pocket maximum of \$5,000 for individuals and \$10,000 for families is met, the medical expenses are covered by the health plan.<sup>11</sup> The theory of the CDHC plan allows patients to "realize economic rewards for making good decisions and

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*Satisfy Patients? Problems with Theory and Practice in Health Insurance Contracts*, 69 BROOK. L. REV. 485, 506-07 (2004); Niko Karvounis, *Patients Managing Chronic Diseases: Not your Average Consumer*, THE CENTURY FOUNDATION, Oct. 30, 2007, <http://www.tcf.org/list.asp?type=NC&pubid=1719>.

<sup>5</sup> Axtell-Thompson, *supra* note 3, at 208.

<sup>6</sup> Mariner, *supra* note 4, at 495.

<sup>7</sup> COALITION FOR AFFORDABLE HEALTH COVERAGE, *Policy Solutions for the Uninsured: Health Savings Accounts*, [http://www.cahc.net/p\\_healthsavings.html](http://www.cahc.net/p_healthsavings.html) (last visited Oct. 2, 2009).

<sup>8</sup> *Id.*

<sup>9</sup> Jessica Greene et al., *Comprehension and Choice of a Consumer-Directed Health Plan: An Experimental Study*, 14 AM. J. MANAGED CARE 369, 369-70 (2008).

<sup>10</sup> Mariner, *supra* note 4, at 504.

<sup>11</sup> COALITION FOR AFFORDABLE HEALTH COVERAGE, *supra* note 7.

bear the economic penalties for making bad ones.”<sup>12</sup> Under CDHC, HSAs have “three primary goals: (1) to promote savings for health related expenses, (2) encourage prudent healthcare spending by providing incentives to consumers, and (3) to provide consumers with the ability to select and fund their own healthcare services.”<sup>13</sup>

### III. IMPROVING ACCESS TO HEALTHCARE THROUGH CDHC AND HSAS

In theory and design, CDHC is a healthcare system that would reduce costs and improve quality of health services overall, which in turn, provides more access to healthcare.<sup>14</sup> Patients can use the money in their HSAs “for any health care, including preventative care, check-ups, prescriptions, dental care, eye care, and the full range of alternative medicine.”<sup>15</sup> CDHC gives patients the freedom to spend their money as they see fit so that “the individual’s goals and preferences regarding care are factored, as much as possible.”<sup>16</sup> This personal autonomy is important because patients can “weigh factors individually and find different tradeoffs within a mix of risks and benefits acceptable or objectionable.”<sup>17</sup>

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<sup>12</sup> Devon M. Herrick, *Consumer Driven Health Care: The Changing Role of the Patient*, 276 NAT’L CTR. FOR POL’Y ANALYSIS 1, at 5 (2005), <http://www.nepa.org/pdfs/st276.pdf>.

<sup>13</sup> Russell B. Cate, Note, *Move over Managed Care – Health Savings Accounts, Small Businesses, and Low Wage Earners: Cost, Quality, and Access*, 4 IND. HEALTH L. REV. 287, 288 (2007).

<sup>14</sup> See Peter Ferrara, *The Obama Health Plan: Rationing, Higher Taxes, and Lower Quality Care*, THE HEARTLAND INSTITUTE 1, 34 (Aug. 6, 2009), [http://www.heartland.org/custom/semod\\_policybot/pdf/25813.pdf](http://www.heartland.org/custom/semod_policybot/pdf/25813.pdf).

<sup>15</sup> *Id.* at 33.

<sup>16</sup> Marshall B. Kapp, *Health Care in the Marketplace: Implications for Decisionally Impaired Consumers and Their Surrogates and Advocates*, 24 S. ILL. U.L.J. 1, 4 (2000).

<sup>17</sup> *Id.* at 29.

Proponents of CDHC maintain that access to healthcare would be improved under this model because the money deposited into HSAs is tax-free and any individual can contribute to an HSA, including other family members and employers.<sup>18</sup> This would encourage people to invest in their healthcare. Money that is deposited into HSAs can be carried over year to year without a penalty or threat of losing the money if not spent within the same year, however, the patient must pay “the required deductible at the beginning of each year.”<sup>19</sup> This feature of CDHC allows flexibility for the patient<sup>20</sup> to decide whether or not to use their money, without financial consequences. The consumer driven system emphasizes patient autonomy and responsibility.<sup>21</sup> These benefits seem to assume a generic patient since no variables are accounted for, such as level of health, education, or income. To determine the likelihood of success under CHDC, specific categories of patients should be analyzed.

#### IV. THE EFFECT OF CDHC AND HSAS

##### A. *The Poor*

The poor comprise one segment of the population in severe need of access to healthcare. They often lead life styles that do not promote good nutrition or the upkeep of adequate living conditions and habits.<sup>22</sup> Additionally, their lack of disposable income does not grant them any advantages to or means of obtaining

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<sup>18</sup> Cate, *supra* note 13, at 295-96.

<sup>19</sup> *Id.* at 296.

<sup>20</sup> *Id.*

<sup>21</sup> Kapp, *supra* note 16, at 29.

<sup>22</sup> Stiehm, *supra* note 4, at 279.

healthcare.<sup>23</sup> The poor in America generally face barriers to healthcare, including: not being able to take time off from work for healthcare related services; not being able to obtain adequate transportation for healthcare needs;<sup>24</sup> and not having the expendable income to spend on adequate healthcare or even preventative care.<sup>25</sup> Without having an opportunity to access medical care, the poor will likely suffer from health issues, and in the case of medical emergencies, they could face extreme financial difficulties.<sup>26</sup>

Under the CDHC plan, the poor would be able to pick and choose what services they need, ideally reducing unnecessary healthcare, thus allowing them to save money.<sup>27</sup> They would, however, likely be conservative in their spending of necessary healthcare services as a method of saving money in their HSA overall, and accordingly, will not receive necessary services.<sup>28</sup> Consequently, the poor would not be able to afford certain services or levels of services because they would not have access to unlimited funds. Because “[v]oluntary choice and willingness and ability to pay are the hallmarks of consumer purchasing . . . [a]bility to pay constrains consumer choice.”<sup>29</sup> Thus, a patient’s access to certain services would be determined by the funds in their HSA.

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<sup>23</sup> Cate, *supra* note 13, at 303-04.

<sup>24</sup> Stiehm, *supra* note 4, at 280.

<sup>25</sup> Leah Snyder Batchis, Comment, *Can Lawsuits Help the Uninsured Access Affordable Hospital Care? Potential Theories for Uninsured Patient Plaintiffs*, 78 TEMP. L. REV. 493, 499 (2005).

<sup>26</sup> *Id.* at 498.

<sup>27</sup> Symposium, *Healthcare Reform in America: Getting Beyond Ideology to True Reform*, 5 IND. HEALTH L. REV. 463, 477 (2008).

<sup>28</sup> *Id.* at 477-78.

<sup>29</sup> Mariner, *supra* note 4, at 493.

Once a patient exhausts all the money in their HSA, their health plan does not cover the remaining costs until they spend enough to meet the high deductible.<sup>30</sup> One problem with HSAs is that people must initially have the money to contribute to them as they pay out-of-pocket until the deductible is met. This means “[t]he gap between money in a health savings account and the high-deductible (this gap could be very high, in a range of \$2,000 to \$5,000 for families) is likely to cause a large number of families with relatively modest income to fall into the category of being ‘underinsured.’”<sup>31</sup> The period in which an individual must pay the deductible is commonly referred to as the donut hole,<sup>32</sup> because it leaves patients with high out-of-pocket costs, which the poor cannot afford. In this way, HSAs do not improve access to healthcare for the poor.

Converting the poor, who are uninsured or underinsured, into a larger group of underinsured, is a pitfall of the CDHC system,<sup>33</sup> and does not provide a pathway to adequate healthcare for the poor. Despite the theories that CDHC would reduce costs and spending, in 2005, people with HSAs and high deductible plans “were more than two-and-a-half times as likely to pay more than 5% of their income in out-of-pocket medical costs . . . then were people enrolled in

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<sup>30</sup> James C. Robinson, *Health Savings Accounts – The Ownership Society in Health Care*, 353 N. ENG. J. MED. 1199, 1200 (2005).

<sup>31</sup> Gail Shearer, Testimony Before the Joint Economic Committee, IMPACT of “Consumer-Driven” Health Care on Consumers 1, 8 (2004), <http://www.consumersunion.org/pub/0225JECTestimonyNoSummary.pdf>

<sup>32</sup> Jessica Greene et al., *Which Consumers are Ready for Consumer-directed Health Plans?*, 29 J. CONSUMER POL’Y 247, 248 (2006).

<sup>33</sup> Shearer, *supra* note 31, at 2, 8.

comprehensive insurance.”<sup>34</sup> These increased out-of-pocket costs are draining on the poor because they have a limited disposable income and they are therefore unable to continually contribute to their HSAs like higher-income people.<sup>35</sup> Since the poor have a limited income, they are more likely to forego medical treatment either to save money or because they do not have the money in their HSA. In the long term, this could cause more critical and expensive health problems.<sup>36</sup> In 2005, the poor delayed or did not receive medical treatment 78% of the time compared to 44.2% for high-income people.<sup>37</sup> Under this theory, the poor would not only become underinsured, but also would not be able to afford necessary care.

The implementation of CDHC in conjunction with HSAs, will not likely increase healthcare access for the poor. HSAs do not provide a means for the poor to access healthcare easily, nor do they reduce costs for the poor.<sup>38</sup> The high deductible requirement makes the poor less likely to receive treatment and it is highly probative that their health will deteriorate as a result.<sup>39</sup> While the idea of CDHC may be significant in terms of controlling healthcare costs,<sup>40</sup> CDHC, in the long term, may stifle the poor more than assist them in accessing healthcare.

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<sup>34</sup> Center on Budget & Policy Priorities, *A Brief Overview of the Major Flaws with Health Savings Accounts 1, 2* (2006), <http://www.cbpp.org/files/hsa-overview.pdf>.

<sup>35</sup> *Id.* at 2-3.

<sup>36</sup> *See, e.g., Id.* at 2; Cate, *supra* note 13, at 297.

<sup>37</sup> Agency for Healthcare Research and Quality, U.S. DEP’T OF HEALTH & HUM. SERVICES, *National Healthcare Disparities Report*, AHRQ Pub. No. 09-0002, 153 (2009), available at <http://ahrq.gov/qual/qdr08.htm>.

<sup>38</sup> Center on Budget & Policy Priorities, *supra* note 34, at 2.

<sup>39</sup> Cate, *supra* note 13, at 303.

<sup>40</sup> Axtell-Thompson, *supra* note 3, at 225.

*B. The Uneducated*

CDHC gives patients more responsibility and control over their healthcare and, as a result, they need to be more informed when making complex and intricate healthcare decisions.<sup>41</sup> Patients must deal with difficult and obscure information regarding cost, coverage, benefits, and providers.<sup>42</sup> Informed decisions are important so that patients are not negatively affected or harmed by their inability to make the ‘correct’ decision regarding their healthcare. Similarly, the less educated will have more difficulty with the added responsibility of CDHC. The variety of patients “will have different information needs, based on their health status, interests and abilities, and roles as simple patients, general consumers, or family decision makers.”<sup>43</sup> This makes CDHC all that more taxing on the uneducated, especially those not familiar with the medical industry.

Uneducated patients will be at a disadvantage under CDHC because their low level of literacy makes them vulnerable to making poor decisions,<sup>44</sup> which will negatively affect their health and their healthcare spending. CDHC places patients and consumers at the same level, but a patient has a different mind set and mental outlook than a consumer.<sup>45</sup> Access to healthcare under a consumer model is obstructed because “[i]llness erodes control” that a patient must possess and ultimately, “illness can cripple the patient as consumer”<sup>46</sup> who must be a

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<sup>41</sup> *Id.* at 214.

<sup>42</sup> *Id.*

<sup>43</sup> *Id.* at 212.

<sup>44</sup> Kapp, *supra* note 16, at 25.

<sup>45</sup> Mark A. Hall & Carl E. Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. 643, 650 (2008).

<sup>46</sup> *Id.*

“seeker of information and maker of decisions.”<sup>47</sup> A patient that is sick or ill cannot make clear, rational, or financially beneficial decisions when they are faced with health concerns, and patients at a lower education level will have even more difficulties accessing healthcare. The immediacy and urgency of some medical issues put patients at a disadvantage because in such a situation, a patient will not be able to research all their options or find the most cost-effective plan, which affects their bargaining power.<sup>48</sup> CDHC detrimentally assumes that patients will foresee healthcare problems and concerns in the future, when in reality, patients are not likely to expect the type of funding necessary for their healthcare needs when they are healthy.<sup>49</sup> Consequently, the patient will not have the needed funds in their HSA.<sup>50</sup> While educational disparities exist, “painting patients with the broad brushstrokes of market logic is counter-productive because in reality we do not all have the same capacity to be effective in efforts to manage our own care.”<sup>51</sup>

### *C. The Chronically Ill*

The chronically ill also require improved access to healthcare as they have a standard or minimum amount of medical care. The high deductible required under CDHC will operate as a barrier to healthcare for the chronically ill.<sup>52</sup> The chronically ill are patients faced with the high costs of medical care on a regular

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<sup>47</sup> *Id.* at 652.

<sup>48</sup> *See* Cate, *supra* note 13, at 300 (alleging that “[t]he very nature of a consumer acting as a patient places one in an inferior bargaining position because the consumer must obtain medical care in some fashion leaving little room for negotiation.”).

<sup>49</sup> *Id.* at 295.

<sup>50</sup> *Id.*

<sup>51</sup> Karvounis, *supra* note 4, at 2.

<sup>52</sup> Jacobi, *supra* note 2, at 566.

basis.<sup>53</sup> 70% of United States healthcare costs are retained by only 10% of patients, most of which suffer from a chronic illness.<sup>54</sup> Contrary to the chronically ill, the CDHC system benefits healthy populations because they will not have on-going or expensive treatments that they repeatedly have to pay for through deductibles.<sup>55</sup> Heightened access to healthcare for the chronically ill will not be realized under CDHC because the high deductible required by HSAs force the chronically ill to pay significantly greater out-of-pocket costs.<sup>56</sup> As a result, each year the chronically ill will be exhausting their HSAs.

The combination of HSAs and high deductibles will not decrease the costs or medical services for the chronically ill because health plans associated with high deductibles will cover any remaining costs after the deductible has been met.<sup>57</sup> People with chronic illnesses cannot forego necessary treatment, and under the consumer driven system, they will have an established amount of expenses each year that will operate as a surcharge or penalty simply because they are chronically ill.<sup>58</sup> In effect, the burden of cost will shift to these chronically ill patients<sup>59</sup> and become a barrier to needed healthcare.<sup>60</sup>

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<sup>53</sup> Karvounis, *supra* note 4, at 1.

<sup>54</sup> *Id.*

<sup>55</sup> Mariner, *supra* note 4, at 506.

<sup>56</sup> Center of Budget & Policy Priorities, *supra* note 34 at 2.

<sup>57</sup> Axtell-Thompson, *supra* note 3, at 211.

<sup>58</sup> Jacobi, *supra* note 2, at 534, 562, 566.

<sup>59</sup> Shearer, *supra* note 31, at 3.

<sup>60</sup> Axtell-Thompson, *supra* note 3, at 211.

## V. CONCLUSION

Under a consumer driven model of healthcare, it is vital that the system “reflect an understanding of the wide variations and inherent limitations of decision making capability in general and, in particular, within the complex realm of health care.”<sup>61</sup> Consumer driven systems of healthcare present numerous barriers and problems for the poor, uneducated, and chronically ill. The very character of CDHC threatens to transform the uninsured into the underinsured because of high out-of-pockets costs.<sup>62</sup> Patients will refrain from getting the routine medical services or preventative care they need.<sup>63</sup> A consumer driven model is not ideal for at-risk patients because “when the consumer is part of the product, responsibility is not some independent value hidden away in an impregnable safe-space of rationality—it’s inextricably tied up with the patient as a whole: his experiences, his feelings, and yes, his education.”<sup>64</sup> Patients are all diverse, but under a consumer driven system, the patients that need the most help are left to suffer and are burdened with rationing their healthcare funds.<sup>65</sup>

CDHC does not improve access to healthcare because of the combination of HSAs and high deductibles, in addition to the complexity and responsibility that adheres to the consumer model.<sup>66</sup> While the current healthcare system in the United States is inadequate and requires improvement, CDHC is not the

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<sup>61</sup> *Id.* at 216.

<sup>62</sup> *See*, Shearer, *supra* note 31, at 8.

<sup>63</sup> Cate, *supra* note 13, at 303.

<sup>64</sup> Karvounis, *supra* note 4, at 2.

<sup>65</sup> Shearer, *supra* note 31, at 2, 8.

<sup>66</sup> *See* Cate, *supra* note 13, at 290, 317-18.

solution.<sup>67</sup> CDHC and HSAs present barriers to healthcare for the poor, uneducated and chronically ill that make them insufficient as a healthcare system. We must continue to find ways to reform and improve upon our healthcare system so costs are not only reduced, but access to healthcare is improved for all Americans.

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<sup>67</sup> See *Id.* at 318; Center of Budget & Policy Priorities, *supra* note 34, at 1, 3; Shearer, *supra* note 31, at 8.