The Powers Report Podcast

Episode 26

Consumerism in Health Care, Part II: Health Care Literacy and Moral Hazard

Welcome to The Powers Report Podcast. I am your host, Janis Powers. The show brings you candid, unique and data-driven perspectives on the health care industry. I believe that any solution that is going to positively impact the American health care system has to satisfy two major criteria: financial viability and behavioral incentive alignment. In other words, access to high quality care can only be achieved if we can afford it, and if we behave in ways that optimize our health. Please subscribe to our show on your favorite podcast app and connect with us on social media. Again, this is Janis Powers, and welcome to The Powers Report Podcast.

This is the second in a series about consumerism in health care. In the last show I talked about how a good chunk of the money-saving ideas in health care were aimed at lowering costs for your employer, the insurance company or the government. That's not saving money for you, the consumer, because you don't see those savings in your wallet.

In this episode I'll talk about the challenges of consumerization in health care as it relates to how people behave. Two factors, health care literacy and moral hazard, will be discussed in the context of two ways people can save money on health care.

First and foremost, anyone who claims that they're going to help consumers lower their health care costs has to account for the fact that the bulk of these costs are paid in fixed, monthly premiums. These premiums run in the hundreds if not (for larger families and older folks) thousands of dollars a month. We need to put savings in perspective. It's kind of ridiculous to expect people to do backflips because they've saved $15 on a prescription when they're paying $600 a month for health insurance.

I've been asked if my company is going to help people figure out how to shop for health insurance. My answer is always an emphatic "No." I presume these individuals ask me the question because they recognize that premiums are a significant monthly fixed cost. They figure that there must be a way to get an inside track to finding lower premiums. Well, not really.

First of all, if you're getting your insurance through your employer, which is how most people get it, your employer has already whittled down the options for you. You choose from the plans selected by them. On the plus side, your employer is contributing a lot towards your insurance coverage, so that's something to be grateful for. That being said, most people who buy insurance on the exchange receive a government subsidy to do so. They have more choice

because they get to pick from different plans. But then again, the coverage is probably not as generous as it is in many employer-sponsored plans.

You're probably aware that the Affordable Care Act mandates that most insurance plans have to cover an expansive array of benefits. That's been a contributing factor to health care premiums rising since the ACA was implemented.

One way around paying for one of these bloated plans, and thereby lowering your premium payments, is to buy a short-term plan. They last about six months and then need to be renewed. You have to qualify for the coverage and a lot of pre-existing conditions might exclude you from getting approved. These plans cover almost nothing that you'd use on a primary care basis. However, if you're not on major medications and/or you don't expect to have any major medical expenses and most importantly, you're willing to take the risk, a short-term plan could be a cost saving stop-gap for a while.

There are other funky options that have been authorized by the Trump administration. Small groups can come together and create their own plans, and these can be cheaper. But they're not national plans. By their nature, the groups coming together are local or regional at best, so it's hard to really "shop." I love alternative insurance options. You just have to be somewhat "in the know" to participate in one of these plans. And again, there are disqualifiers unique to each of them.

One of the biggest problems in trying to find ways to lower insurance premiums is that people can lose sight of value. Just because something costs less doesn't mean that it's better. Some people are willing to pay over a thousand dollars for the latest phone because they see value in it. Others will get a cheaper version of the same phone because they don't care about status and they don't need all the bells and whistles that the latest product has to offer.

We know the health care industry makes it really hard to discern value because the terms of insurance plans are so hard to understand. Further, most of us can't predict what we might need in a given year, which further challenges us to make an informed value-based decision.

I'd argue that the most important decision you can make when shopping for health insurance isn't the amount of the monthly premium. It is whether the physician you like is covered under the plan you're shopping for. That way, you know what you're getting. You have a relationship with this person, they have your medical history, the staff knows you. All of these things help make your health care experience better. All of these things make you more health literate.

That's why saving yourself a $50 a month or even a few hundred dollars a month in exchange for cutting yourself off from your health care network is just not worth it. Why? If you don't have a trusted provider, you'll be less likely to seek medical care. Being sick is hard physically and emotionally. The idea of starting anew when you're at your most vulnerable is hard for anyone.

What if this new doctor recommends something you don't think you need? Will you have the confidence to discuss it with them? What if the provider has a nurse call you with the recommendations? It's much harder to ask for explanations over the phone from someone who may simply be relaying messages. And that may be the point. The new doctor may not want to talk to you. You just don't know.

This trust issue gets to the heart of one of the reasons why the consumerization of health care is so difficult. Doctor/patient relationships have slipped precipitously over the past few decades. Back in the day, the Health Maintenance Organization (HMO) concept was designed to address this issue. The primary care doctor was supposed to coordinate all the care needs of the patient. That meant that in order to see a specialist, you had to see your primary care doctor first. People didn't like that. It was inconvenient and took too much time. So the models shifted, and some insurers allowed patients to go directly to specialists. In some cases it *is* more expedient. But this approach has contributed to the disintegration of coordinated health care and that's led to poorer outcomes for too many people.

Some people like the freedom of picking their own specialist, but they may not be using the right criteria to do it. Some patients are seeking out providers not based on what a trusted referring doctor might say, but on market-based, crowd-sourced metrics like Yelp or online reviews. These reviews are notoriously flawed. Amazon has a chronic problem with product reviews on its site that are not posted by real customers.

And let's face it, social media has the ability to skew perception. If a patient with a huge social media following has a less than perfect experience with a doctor, that physician could get flooded with terrible reviews, posted by people he or she has never met. Why? Because the doctor was ten minutes late for an appointment? Or because the doctor inadvertently removed the wrong kidney? Social media doesn't care. You should.

I'm not downplaying the role of technology in helping advance the health care industry. My company is developing tools to help patients navigate the health care system because there are so many unknowns. And there are plenty of self-diagnosing tools available. Many believe the vast majority of care will become automated. Fine. Good. But health care is about humans. Robots can't give you a hug.

I think the best health care consumers are the ones who understand this. They will take the time to look beyond price and see what kind of health care they're going to get. This should save money because these individuals are receiving preventive care coaching, seeking out care when they need it and challenging doctors to prescribe only what's needed to best position the patient to be as healthy as they can be.

The unfortunate reality is that most people are not like this. They're not prepared to make wise decisions in spending their health care dollars. Which brings me to the second challenge to health care consumerism: moral hazard.

In discussing health care literacy, I talked about the importance of looking beyond lowering premium prices when selecting a health plan. Yet there is another way to lower your premiums. And that's to go with a high deductible health plan. In exchange for lower monthly premiums, you pay a higher deductible. A HDHP may be good for you for the same reasons that a short-term plan can work. If you are relatively healthy and don't expect major medical expenses, a HDHP may for you. On the plus side, it is less risky than the short-term plan because your coverage is going to be broader. The HDHP covers a lot of the basic primary care stuff, so you won't have to pay out of pocket for it.

Another benefit is that you qualify to open a Health Savings Account, or an HSA. I did a whole podcast on the glories of HSAs last year (1). HSAs are great because you can put a certain amount of money into a personal financial account pre-tax. Many employers contribute to employee HSA accounts too.

You can use the HSA money on qualified medical expenses, just like a Flexible Spending Account. However, if you don't use all the money in your HSA, it stays in the account. In the Flexible Spending Account, you lose the money. Further, if your HSA is structured properly, you should be earning interest on the balances in the account. There's no tax on that investment income, which is another benefit. And then you can use the money for Medicare premiums later on.

At one point, my company was going to go to market as an HSA. The benefits are wonderful – on paper. Then we started talking to people who are enrolled in them. While the HSA seems like it is a consumer product, it really isn't. Over three quarters of new HSA accounts were generated through an employer for the first half of 2020 (2). There are some great companies that market to individuals. But the HSA product is somewhat complex to understand and only a sliver of people qualify for them (again to qualify you must have a HDHP, have to have the money to put in the HSA and you have to not use the HSA from your employer, if the employer offers one.) I love the product, but we didn't think it was a worthwhile venture for us.

We also learned that HSA owners seem to fall into two buckets.

At one end of the spectrum are the people who maximize the contribution levels for the HSA every year and then don't spend it. They use it strictly as an investment account. These folks have the money to pay out of pocket for their medical expenses, rather than drawing down funds from the HSA account. Their view, and it is legit, is that they'd rather keep the money in the account and have it earn interest over decades rather than get the tax-free benefit in the short term. (Actually, they can have both because HSA holders can save their receipts and then claim the expenses many years later, after the account has generated investment income that can theoretically fund the old medical expenses. I wasn't kidding when I said these things were kind of complicated!)

Interestingly, there's been a big push recently promote HSAs strictly as an investment vehicle. In fact, half of employers are positioning the HSA as a retirement savings vehicle, not a health

savings vehicle (3). I can see why an HSA company would do this. The longer the funds stay under their management, the more money they can make. Yet in theory the HSA was started to help people save on their health care expenses, not to have another tax-advantaged investment account.

Which brings me to the other set of people using HSAs: the folks who put money in the fund (or have their employer do so) because the tax benefits are so great, but then they don't use it on health care. And they don't use their other money on health care. They're on a high deductible health plan, so they want to avoid engaging with the health care system because they risk having to pay for the care out of pocket. Sure, the HSA was designed to help mitigate that problem. But since no one knows what kind of a bill they're going to get socked with, some folks would rather avoid care altogether and put away whatever money they can in case something really bad happens.

The problem is so pervasive that the Trump administration had to pass a law requiring insurers who offer high deductible health plans with an HSA to cover insulin (4). They did this because diabetics liked having lower premiums with high deductible health plans but then didn't pay out of pocket for the medications they needed. Imagine you're one of these folks who's got a high deductible health plan and an employer-sponsored HSA. You actually have the cash to spend on your medical needs – which was the point of employers setting these things up in the first place – but then you don't use it for something so basic, like insulin.

This is the moral hazard problem. If people are empowered to make health care decisions, are they going to make the right ones? If they don't and they get very sick and they can't afford their medical care, then it becomes everyone else's problem.

There are many Americans that do not take care of themselves today. Some do it by choice. They simply don't care and aren't willing to make the effort to be healthy. Other folks are impacted by circumstances out of their control, like poor education, poor public health in the community where they live, mental health issues, cultural behaviors that reinforce negative health habits, the list goes on. I'd argue in most cases, poor health status is a combination of both controllable and uncontrollable factors.

That's why it's hard for one American to trust another American to spend their health care dollars responsibly. How can we believe consumerization in health care is going to work if we have a subset of the population that is relatively unhealthy which cannot and/or will not spend the money responsibly?

One thing we've heard over and over with the Covid-19 pandemic is that the health care system is inequitable. People of color, people who have lower incomes, people who are less educated – these folks are suffering from the virus more than everyone else. This is a tragic situation. I think the root cause of it is income inequality. I truly believe that in America, money transcends race and education in leading to a better life. It is the great equalizer. The same is true in health care. The more money you have, the better health care you're going to get.

This has been a notorious problem with Medicaid, the government health program for the poor. Medicaid's reimbursement rates are so low that some doctors refuse to take Medicaid patients. With fewer people accepting the insurance, it's harder to get in to see a doctor in the first place. Wait times are longer. Longer wait times can exacerbate health conditions.

Further, these patients don't get the choice of doctors that other people may have. They can't create the patient provider relationships that fosters health literacy the same way other folks can. That puts them at a distinct disadvantage.

Many people see this income inequality issues as a major challenge to bringing consumerism to health care. I don't.

Americans have rejected the single payer option, and with good reason. We are too big and way too diverse to have a one-size-fits-all health care system. Most importantly, we've seen a failure of Congress to act cooperatively for decades. Both political parties are at fault. We can't implement policies promoted by what one half of Americans want, only to have these policies shredded by what the other half of Americans want. Having policy makers dictate our health care system has failed. It's time for the market to take over.

In the short term, and by that I mean at least this decade, the government should focus on fixing Medicaid and Medicare. I've got suggestions. One of my favorite podcasts is all about ideas on how to fix Medicaid (5). There are a lot of great things that can and should be done to this critical program that serves one in five Americans.

In the meantime, we need the Americans on private insurance to start market-testing some consumer-based health care ideas. Early adapters are more risk loving and are willing to spend money to try new things. The first iterations of new products oftentimes aren't in the price range of all Americans. They can't be. They're experimental. Consumers tell the companies what they like and don't like about the products. Companies adjust and get better at making the product. More people buy it. It gets cheaper. Then everyone can afford it.

We need the government to give consumers protection, to do oversight that makes sure patients are safe. We need the government's guidance. That's different from running everything. If the government wants to run everything, they should prove that they can by cleaning their up own house and fixing Medicaid and Medicare. Until then, we entrepreneurs are going to take our ideas to market so we can help Americans be as healthy as they can be.

This is The Powers Report Podcast. Please subscribe to our show and please follow me, Janis Powers, on social media. Please see our website at powersreportpodcast.com to submit questions on the Contact page. I look forward to hearing from you. Thanks so much for listening!

1. Powers, Janis. “Episode #15 – Health Care’s Option 3: The Market Option,” The Powers Report Podcast, August 22, 2019, https://thepowersreportpodcast.blubrry.net/2019/08/22/episode-15-health-cares-option-3-the-market-option/.
2. “2020 Midyear HSA Market Statistics & Trends Executive Summary,” Devenir Research, September 1, 2020, https://www.devenir.com/research/2020-midyear-devenir-hsa-research-report/.
3. Greenan, Hattie. “A New Looks for HSAs – Retirement Savings,” Plan Sponsor Council of America, August 20, 2020, https://www.psca.org/news/PR_2020_HSAreport.
4. Armour, Stephanie. “Trump Administration Moves to Shift Patients’ Chronic Illness Costs to Insurers,” July 19, 2019, *The Wall Street Journal*, https://www.wsj.com/articles/patients-with-high-deductible-health-plans-to-get-greater-flexibility-11563372139.
5. Powers, Janis. “Episode #16 – Pros and Cons of Medicaid Expansion,” The Powers Report Podcast, April 1, 2019, https://thepowersreportpodcast.blubrry.net/2019/04/01/episode-6-pros-and-cons-of-medicaid-expansion/.