Consumer-Driven Health Care: Promise and Performance

James C. Robinson
University of California, Berkeley
and
Paul B. Ginsburg
Center for Studying Health System Change

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OVERVIEW

- CDHP 1.0: The Promise
  - Insurance: the high-deductible health plan
  - Delivery: the focused factory
  - Sponsorship: beyond employment-based coverage
- CDHP 2.0: The Performance
  - Insurance: benefits, networks, medical management
  - Delivery: consolidation
  - Sponsorship: public programs with private management
- Managed consumerism

CDHP 1.0: Insurance

- Benefits: High-deductible health plan
  - Subsidies via tax preference for HSA
- Networks: Any willing provider
  - Away from managed care network contracting
  - Prices set by providers with an eye on individual WTP
- Medical management: self-managed care
  - Away with UM, MM, DM, CM
  - Internet-based info on prices, quality, convenience

CDHP 1.0: Delivery of Care

- Disintermediate the hospital conglomerate
- Focused factories
  - Specialty hospitals
  - Single-specialty, not multi-specialty, medical groups
  - Ambulatory surgery, diagnostic centers
  - Condition-specific clinics (cancer, diabetes)
  - Retail clinics

CDHP 1.0:
Sponsorship of Coverage

- Limit the role of paternalism and social insurance
- Away with employment-based insurance in favor of individually-purchased insurance
  - Level the tax exclusion playing field
- Reverse tide towards public programs
  - Avoid crowd-out of private insurance: Medicaid, SCHIP
  - Convert Medicare to MSA or FEHBP

CDHP 2.0: Overview

- Insurance
  - Benefit design, networks, medical management
- Delivery
  - Consolidation and diversification of hospital systems
- Sponsorship
  - Slouching towards public sponsorship

Insurance 2.0: Benefit Design

- High deductible plans, with or without HSA, have grown slowly, often due to herding consumers without choice (full replacement)
  - PPO rather than HDHP: moderate cost sharing
- Innovation: value-based benefits
  - First dollar coverage for cost-effective drugs, services
  - Increased (paternalistic) subsidies for healthy behaviors

Insurance 2.0: Network Design

- Contrary to CDHP rhetoric, consumers choose products with managed care networks
  - All HDHP use PPO networks
  - HMOs far dominate HDHP
  - Price discounts (wholesale purchasing) are key
- High-performance networks
- Specialty networks: radiology, transplant, bariatric
- Coordinate with behavioral, pharmacy, dental

Insurance 2.0: Medical Management

- Contrary to CDHP rhetoric, medical management is part of every insurance product
  - Disease management for chronic conditions
  - Case management for complex conditions
  - Wellness and prevention programs for all
  - Utilization management for possibly inappropriate care
- These are offered by main insurer or outsourced
- Most are voluntary, but increasingly they come with financial incentives for cooperation and compliance

Delivery of Care 2.0: Consolidation

- Hospital-centered delivery systems (IDS) have not been disintermediated; they have grown
- In many markets, hospitals are employing MDs
- Many hospital markets are very consolidated
  - Financial margins have improved
- Physician market is not consolidated
  - No trend towards multi-specialty medical groups
  - Some trends towards single-specialty groups

Delivery of Care 2.0: Diversification

- IDS have diversified into specialty hospitals, ambulatory surgery, retail clinics, etc.
  - Ownership or joint ventures
  - Focused factories are partners in many markets
- IDS still faces competition from physician-owned facilities, esp. office-based tests and procedures
- Service line structures within hospitals permit many of advantages of focus and incentives

Delivery 2.0: Physician Services

- The CDHP vision of specialty services displacing primary care, multi-specialty services has soured
  - Physician conflicts of interest
    - Oncology: buy and bill
    - Orthopedics and cardiology: “consulting” payments for devices
    - Radiology, urology: self-referral to equipment in MD office
  - Single-specialty groups: cartel pricing and anti-trust
  - Violation of professional and community expectations
    - Refusal to treat uninsured, Medicaid, ER coverage

Sponsorship 2.0: Erosion of Private Sponsorship

- Employment-based coverage has continued to erode, as advocated by CDHP, though slowly
- But individual market for insurance has dawdled
  - Underwriting, high administrative costs, fraud
- Some states favor “connector” models to help non-employment based coverage, but this is highly regulated and not “consumer-driven”

Sponsorship 2.0: Expansion of Public Sponsorship

- Conservatives have fought losing battle against expansion of public sponsorship
  - Medicare growing as society ages
  - Medicaid expansions are popular with states
  - SCHIP expansion vetoed but likely if Dems win
- Public sponsorship uses private health plans
  - Medicare Advantage
  - Medicaid managed care

Managed Consumerism

- Consumer choice is important: efficiency and autonomy
- But consumers need meaningful information, incentives, options, protections, and subsidies
- This creates enduring roles for health plans, integrated provider organizations, and (public and private) sponsors
- Consumerism and managed care are complements more than they are substitutes
  - “Managed consumerism”
  - “Consumer-driven managed care”

Managed Consumerism: Insurance

- Value-based benefit design
- High performance networks and centers of excellence
  - Continuing virtues of multi-specialty medical groups
  - Continuing virtues of coordinated care
- Payment incentives
  - Episode pricing, pay-for-performance, medical home
- Medical management
  - Incorporating DM with direct delivery of care
  - Case management

Managed Consumerism: Delivery of Care

- Imperative to foster both coordination and focus
  - Multi-specialty medical groups provide the best care
  - Service line organization within hospitals fosters accountability for all costs and over entire episodes
  - Mergers for the sake of size and leverage do not add efficiency: there are no inherent economies of scale
- Multiple models will emerge, compete, and morph
- Let the best model win: transparency, anti-trust enforcement, IT interoperability, consumer choice

Managed Consumerism: Sponsorship of Coverage

- Individual responsibility without community accountability undermines fairness
  - Beyond “consumer-driven” health care
- Community responsibility without individual accountability undermines incentives
  - Beyond “single payer” health care
- Important roles for consumers and patients, physicians and hospitals, employers, insurers, government
- A bipartisan approach: fairness and accountability

Conclusion: Balancing Individual and Social Responsibility in Health Care

- Individual responsibility with accountability
  - Value-based benefits
  - High-performance networks and payment incentives
  - Incentives for wellness and disease prevention
- Community responsibility
  - Universal coverage with subsidies
  - Population-based approach to chronic care
  - Wellness and public health