Consumer-Driven Health Care: Promise and Performance

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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
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
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
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.
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.
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
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
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”
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