MANAGED CONSUMERISM IN HEALTH INSURANCE

Harvard/JFK Health Care Delivery
March 2, 2006

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University of California, Berkeley
OVERVIEW

- The changing roles of health insurers
- Consumer-driven health insurance
  - Structure and limitations
- Second generation consumerism
- Managed consumerism
What Do Health Plans Do?

<table>
<thead>
<tr>
<th>Benefit Design</th>
<th>Network Design</th>
<th>Medical Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Conditions covered:</strong></td>
<td><strong>Providers covered</strong></td>
<td><strong>Utilization mgmt.:</strong></td>
</tr>
<tr>
<td>ü“Medical necessity”</td>
<td>Payment rates</td>
<td>üPrior authorization</td>
</tr>
<tr>
<td><strong>Services covered:</strong></td>
<td>üPrice discounts</td>
<td>üPCP gate-keeping</td>
</tr>
<tr>
<td>üDrugs, maternity?</td>
<td>Sub-networks, tiers</td>
<td>Disease management</td>
</tr>
<tr>
<td><strong>Consumer cost sharing:</strong></td>
<td>üCenters of Excellence</td>
<td>Case management</td>
</tr>
<tr>
<td>üDeductible, copays</td>
<td>Ancillary networks</td>
<td>Wellness incentives</td>
</tr>
<tr>
<td><strong>Health Savings Account</strong></td>
<td>üBehavioral, dental</td>
<td></td>
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- **Medical Management**
  - Utilization mgmt.:
    - Prior authorization
    - PCP gate-keeping
  - Disease management
  - Case management
  - Wellness incentives
### Four Forms of Health Care

<table>
<thead>
<tr>
<th></th>
<th>Catastrophic</th>
<th>Chronic</th>
<th>Acute</th>
<th>Wellness</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Costly</strong></td>
<td>Costly</td>
<td>Moderate cost</td>
<td>Moderate cost</td>
<td>Low cost</td>
</tr>
<tr>
<td><strong>Unpredictable</strong></td>
<td>Unpredictable</td>
<td>Predictable</td>
<td>Episodic</td>
<td>Desirable</td>
</tr>
<tr>
<td><strong>High volume leads to lower costs, better quality</strong></td>
<td>High volume leads to lower costs, better quality</td>
<td>Continuity, not volume, is key to better quality, cost</td>
<td>Neither volume, not continuity are key; focus on prices</td>
<td>Key is encouraging utilization</td>
</tr>
<tr>
<td><strong>Patients willing to travel for care</strong></td>
<td>Patients willing to travel for care</td>
<td>Patients unwilling to travel</td>
<td>Some patients willing to travel</td>
<td>Patients not willing to travel</td>
</tr>
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Managed Care Expanded the Health Plan’s Functions

- Benefit designs
  - Comprehensive: wellness, behavioral, drugs
- Network designs
  - Limited choice, integrated delivery, capitation
- Medical management
  - Gatekeeping, prior authorizations
**Managed Care (HMO) Functions**

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<td>Case management</td>
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<td>Chronic Care</td>
<td>Covered</td>
<td>Narrow network, capitation?</td>
<td>Disease management (limited programs)</td>
</tr>
<tr>
<td>Acute Care</td>
<td>Covered</td>
<td>Narrow network of providers, facilities</td>
<td>Utilization management (prior authorization)</td>
</tr>
<tr>
<td>Wellness Care</td>
<td>Covered</td>
<td>Primary care emphasis</td>
<td>Primary care coordination (gatekeeping)</td>
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“Consumerism” as Alternative to Managed Care

- Tighten up on benefit design
  - Higher consumer cost sharing
- Lighten up on network design
  - Broader networks, less capitation
- Lighten up on medical management
  - Less UM, more voluntary DM
(First Generation) Consumer-Driven Health Insurance

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<td>Covered</td>
<td>Non-selective network (limited COE)</td>
<td>Case management (limited programs)</td>
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<td>Chronic Care</td>
<td>“Donut Hole”</td>
<td>Non-selective network</td>
<td>Disease management (limited programs)</td>
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<tr>
<td>Acute Care</td>
<td>HSA with high deductible</td>
<td>Non-selective network</td>
<td>24 hour RN call line</td>
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<tr>
<td>Wellness Care</td>
<td>Covered (limited list)</td>
<td>Non-selective network</td>
<td>Web-based info (limited offerings)</td>
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The Limitations of First Generation Consumerism

- Most costs and quality problems occur for severely ill patients who are past their deductible, HSA and out-of-pocket max
- Broad, unselective provider networks are expensive and have variable quality
- Geographic variations in use, cost, quality
Re-Thinking Benefit Design

- Deductible + HSA creates “too little” coverage for chronic care (donut hole) and “too much” coverage above OOP maximum
- Rely on coinsurance for broad range of care
- Catastrophic care: cost sharing ineffective
- Wellness: cost sharing counter-productive
Re-Structuring Benefit Design

- Less reliance on deductible and HSA
  - Low deductible, small donut hole
- More reliance on coinsurance
  - Cost-consciousness should extend above deductible and to services paid thru HSA
- Catastrophic care: rely on network, MM
- Wellness care: small copay or free
Re-Thinking Network Design

- Extensive variation in provider costs and quality stimulates new network designs
- Narrower, less costly provider networks
- Cost sharing varies by provider cost
  - Tiered copays; coinsurance as auto-tiering
  - Pay-for-performance
- Consumers have choice, but if they use the more efficient providers, they have lower cost sharing
- Choice at time of care supplements choice at time of insurance enrollment
Re-Structuring Network Design

- Extend COE to more services
  - CABG? Bariatric surgery?

- Narrower networks of efficient providers
  - Hospital, specialist tiers? Sub-networks?
  - Radiology? Specialty pharmacy?

- Maintain broad choice for wellness, primary care providers, with narrower networks for specialists, facilities, distributors
Re-Thinking Medical Management

- Most costs incurred by very sick enrollees
  - Cost sharing, narrow networks are of limited effectiveness in managing care for them
  - Medical management programs need to cover broader range of conditions/services
  - Medical management programs need to vary resource intensity with extent of potential savings from intervention
Re-Structuring Medical Management

- Catastrophic: channeling to Center of Excellence, case management for ongoing coordination of care
- Chronic: broader range of DM programs
- Acute: coordination for pre/post surgery, expensive ambulatory tests, procedures
- Wellness: more extensive web-based info and self-management tools and options
## Second-Generation Consumer-Driven Health Insurance

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<td>HSA with low deductible</td>
<td>Selective, discounted networks</td>
<td>24 hour RN call line</td>
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<td>Wellness Care</td>
<td>Covered (extensive list)</td>
<td>Non-selective, broad network</td>
<td>Surgical coordination Outcomes data</td>
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The Limits of Health Plan Initiatives

- Insurers’ benefit, network, and medical management strategies are important
  - But major improvements in cost, quality must involve the providers of care
  - Patient preferences and perceptions also exert major influence on some forms of care
- Insurer initiatives must adjust to the characteristics of particular services
Adjusting Incentives to Characteristics of Services

- The evidence on geographic variations in practice patterns and care utilization highlights two forms of variability:
  - Some services are influenced by consumer preferences and incentives
  - Other services are influenced by physician supply/training and incentives
- Incentives (benefit, network, MM) should target the decision-maker (provider and/or patient)
## Adjusted Benefit and Network Incentives, by Type of Health Service

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<td>“Supplier-induced demand” Benefit incentives: mild Network incentives: strong</td>
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### Notes
- **Discretionary care**
  - Benefit incentives: strong
  - Network incentives: strong
  - Ex: Diagnostic radiology

- **Supplier-induced demand**
  - Benefit incentives: mild
  - Network incentives: strong
  - Ex: Selection of implant vendor

- **Moral Hazard**
  - Benefit incentives: strong
  - Network incentives: mild
  - Ex: Brand v. generic drug

- **Medically necessary**
  - Benefit incentives: mild
  - Network incentives: mild
  - Ex: Appendectomy
Demand as a Lever on Supply

- The heavy lifting of health care reform needs to happen on the supply side.
- But reform of the demand side is essential to provide grass-roots support for priority-setting, tradeoffs, limits.
- Cost sharing is not system reform; it is a lever to help system reform.
What We Have Learned

The backlash against managed care:

You can say no, and then, yes.
You cannot say yes, and then, no.

The coming backlash against consumerism:

High deductibles penalize the poor and sick.
Networks, medical management are key.
Managed Consumerism

- The enduring insight of managed care is that coordination, culture, incentives for providers are central to quality, efficiency.
- The enduring insight of consumerism is that patients respond to information and incentives, and must have final authority.
- The health care system needs to combine management tools with consumer choice.