



MANAGED CONSUMERISM IN HEALTH INSURANCE

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Professor James C. Robinson
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?

Benefit Design	Network Design	Medical Management
<p>Conditions covered: ➤ “Medical necessity”</p> <p>Services covered: ➤ Drugs, maternity?</p> <p>Consumer cost sharing: ➤ Deductible, copays</p> <p>Health Savings Account</p>	<p>Providers covered</p> <p>Payment rates ➤ Price discounts</p> <p>Sub-networks, tiers ➤ Centers of Excellence</p> <p>Ancillary networks ➤ Behavioral, dental</p>	<p>Utilization mgmt.: ➤ Prior authorization ➤ PCP gate-keeping</p> <p>Disease management</p> <p>Case management</p> <p>Wellness incentives</p>



Four Forms of Health Care

Catastrophic	Chronic	Acute	Wellness
Costly	Moderate cost	Moderate cost	Low cost
Unpredictable	Predictable	Episodic	Desirable
High volume leads to lower costs, better quality	Continuity, not volume, is key to better quality, cost	Neither volume, not continuity are key; focus on prices	Key is encouraging utilization
Patients willing to travel for care	Patients unwilling to travel	Some patients willing to travel	Patients not willing to travel



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

	Benefit Design	Network Design	Medical Management
Catastrophic Care	Covered	Centers of Excellence	Case management
Chronic Care	Covered	Narrow network, capitation?	Disease management (limited programs)
Acute Care	Covered	Narrow network of providers, facilities	Utilization management (prior authorization)
Wellness Care	Covered	Primary care emphasis	Primary care coordination (gatekeeping)



“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

	Benefit Design	Network Design	Medical Management
Catastrophic Care	Covered	Non-selective network (limited COE)	Case management (limited programs)
Chronic Care	“Donut Hole”	Non-selective network	Disease management (limited programs)
Acute Care	HSA with high deductible	Non-selective network	24 hour RN call line
Wellness Care	Covered (limited list)	Non-selective network	Web-based info (limited offerings)



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

	Benefit Design	Network Design	Medical Management
Catastrophic Care	Covered	Centers of Excellence	Case management (extended programs)
Chronic Care	Covered with coinsurance	Sub-networks, tiers, pay-for-performance	Disease management (extended programs)
Acute Care	HSA with low deductible	Selective, discounted networks	24 hour RN call line Surgical coordination Outcomes data
Wellness Care	Covered (extensive list)	Non-selective, broad network	Web-based info (extensive offerings)




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, M/M) should target the decision-maker (provider and/or patient)



Adjusted Benefit and Network Incentives, by Type of Health Service

	Use of Health Service is not Consumer Demand-Sensitive	Use of Health Service is Consumer Demand-Sensitive
Use of Health Service is not Sensitive to Provider Supply and Incentives	<p>“Medically necessary”</p> <p>Benefit incentives: mild</p> <p>Network incentives: mild</p> <p>Ex: Appendectomy</p>	<p>“Moral Hazard”</p> <p>Benefit incentives: strong</p> <p>Network incentives: mild</p> <p>Ex: Brand v. generic drug</p>
Use of Health Service is Sensitive to Provider Supply and Incentives	<p>“Supplier-induced demand”</p> <p>Benefit incentives: mild</p> <p>Network incentives: strong</p> <p>Ex: Selection of implant vendor</p>	<p>“Discretionary care”</p> <p>Benefit incentives: strong</p> <p>Network incentives: strong</p> <p>Ex: Diagnostic radiology</p>



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