Blending Supply-Side Approaches with Consumerism

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Presentation to Second National Consumer-Driven Healthcare Summit, September 26, 2007

Early Models of Consumerism Were Demand-Side Strategies

- Financial incentives to patients at point of service
- Information support on quality and prices for services
- Information support on treatment alternatives
- Focus on actions initiated by consumers
  - Choosing a provider
  - Making treatment decisions
  - Physicians might support patients as their agents

Limitations of Early Models

- Lack of incentives applying to expensive care
  - Majority of spending not affected by incentives
- Limits on how much risk consumers can bear
  - Sacrificing core reason for insurance: protection against financial consequences of major illness
- Consumer appropriately dependent on physician for myriad of detailed treatment decisions

Directions for More Effective Demand-Side Approach

- Value-based benefits design
  - Less cost sharing for high value services
    - Evidence-based regimens for chronic disease
  - More cost sharing for services with small or uncertain benefits
- Vary cost sharing by income
- Integrate indemnity concepts into benefit structure
  - e.g. reference price for implants

Recent Insurer Augmentation of Demand-Side Strategies (1)

- Negotiation of provider unit prices through consumer incentives to choose tiers
- Most advanced in pharmaceuticals
  - Creation of tiers (e.g. preferred brand) to negotiate
    - Ability to shift consumers determines insurer/PBM clout
    - Simplifies consumer decision making
      - Obviates need for gathering of price information by consumer
    - Constrained by consumer/employer views on magnitude of incentives

Recent Insurer Augmentation of Demand-Side Strategies (2)

- High performance networks reflect similar strategy
  - (discussed below)
- Improve information support
  - Provide analyzed—instead of raw--information on quality and price
    - Per episode cost rather than hospital charge master
    - Ratings or grades of provider quality rather than detailed scores

Potential for "Supply-Side" Complements

- Evidence of large differences in efficiency and quality across providers
  - Analysis of geographic differences in spending
    - Higher spending does not mean higher quality
  - Analyses of differences in efficiency of prominent academic hospitals
  - Low costs of selected famous medical centers, e.g. Mayo
  - Numerous anecdotes of large increases in quality and efficiency from reengineering

Engage Consumer Decisions to Motivate Provider Change

- Market share shift to providers with better quality/efficiency
- Some direct consumer/societal benefits from shifting market share
- Potential for much larger societal benefits from provider motivation to improve

Current Benefit Structures (Including CDHP) Accomplish Little of This

- Little variation in patient per service out-of-pocket cost among network providers
  - Copayment for office visits and hospital stays
  - Amount applied to deductible or coinsurance based on uniform fee schedule
- Consumers would rather not shop for units of care
  - Their interest is full costs for episode of care
  - Very limited data on cost per episode
    - None covering all providers involved

How Can Consumer Shop for Efficient Episodes?

- Theoretical ideal system
  - Insurer reference price per episode
  - Groupings of providers (or the patient's physician) quote price per episode
  - Patient pays difference between provider price and reference price
    - Plus other cost sharing
  - Quality data by groupings of providers by episode type

Barriers to Ideal (1)

- No motivation for providers to come together to offer global price
- Physicians natural leaders of a grouping
  - But cannot handle risk of patient variation in need for other providers' services
- Hospitals have financial wherewithal to do this
  - Trend towards physicians aligning with single hospital

Barriers to Ideal (2)

- Quality data much more limited than ideal
- Consumers may not be ready for large incentives to favor certain providers
- Providers will resist such a competitive framework

Potentially Feasible Approaches

- Centers of excellence
- High performance networks
- Consumer component of P4P

Centers of Excellence

- Insurer identifies center on basis of quality and efficiency
  - Single payment to hospital and physicians
    - Incentive for the group to work on efficiency and quality
  - Incentive to consumers to choose the center

High Performance Network

- Assess physicians on quality and costs per episode of all providers involved in a patient's care
- Consumer incentives to use high-performing physicians
- Insurers need to support physicians with data on claims from other providers for care of their patients
  - Hospitals
  - Outpatient facilities
  - Prescription drugs
  - Expands range of physician options to increase efficiency

Lessons from Virginia Mason Experience Reengineering under HPN

- Large gains in efficiency and quality for selected conditions
  - Efficiency and quality gains usually came together
  - Significant investment in management resources
  - Savings in drug costs and ED use important in some cases
- Aetna support with claims data a critical ingredient
- Structure of FFS payment made clinical success a financial liability
  - Reductions in physician/outpatient facility services disproportionately the highly profitable ones
  - Implication that reimbursement reform a prerequisite to significant physician practice efforts to improve per episode efficiency

Potential Innovations in P4P

- Expected introduction of per episode criteria into P4P
  - Announcement by Integrated Healthcare Association
- Can a consumer component to P4P be developed?
  - Probably not feasible to vary patient cost sharing by P4P rewards
  - But P4P transparency (rewards accessible to consumers) could lead to some shifts and greater provider responsiveness to P4P

Conclusion

- Major opportunities for societal gains in efficiency and quality lie in improvements by providers
- Consumerism needs to be transformed into a force for these changes
- Significant analysis of data and innovation in benefit structures by insurers required for this
  - Reform in physician reimbursement led by Medicare a key ingredient