A New Ownership Society in Health Care

Consumer-Driven Healthcare Summit
September 26, 2007

James C. Robinson
Editor-in-Chief, Health Affairs
OVERVIEW

- The old ownership society: consumerism
- Towards a new ownership society
  - Innovation in insurance benefits and networks
  - Innovation in the organization of health care delivery
- Managed consumerism
- A new ownership society in health care
The Old Ownership Society in Health Care

- Disintermediation of employers and insurers
- Health insurance
  - Benefit design: high deductibles with HSA
  - Networks: no managed care networks or capitation
    - Definity, Lumenos, etc.
- Health care delivery
  - Physician-driven specialty providers
  - Specialty hospitals: the focused factory
    - MedCath, etc.
Towards a New Ownership Society

- Insurance
  - Benefit design
  - Networks and provider payment incentives
  - Sponsorship: role of employers and government

- Organization of care
  - Physician-driven specialty services
  - The IDS meets the focused factory
  - Medical management and wellness programs
High deductible plans, with or without HSA, have grown slowly, often due to herding consumers without choice (full replacement)

Innovation: value-based benefits
- First dollar coverage for cost-effective drugs, services
- Increased focus on comparative efficacy, CEA
- Increased (paternalistic) subsidies for healthy behaviors
Contrary to CDHP rhetoric, consumers choose products with managed care networks.

Contrary to CDHP rhetoric, no one likes FFS:
- Experiments with pay-for-performance
- Considerable interest in episode-based payment
- Discussion of “value-based payments” for providers

CDHP dis-intermediated:
- WLP buys Lumenos, UHG buys Definity
Coverage Sponsorship 2.0

- Contrary to CDHP rhetoric, individual insurance market stagnates, uninsured rises rapidly
- Employers seek to continue some form of sponsorship, while limiting cost exposure
- Continued growth in public programs, albeit with increased outsourcing of management
  - Medicare Advantage
  - Medicaid managed care
Physician Services 2.0

- 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
CDHP “focused factories” have not displaced incumbents, who have co-opted or displaced them
- Retail clinics partner with or managed by hospitals
- Ambulatory surgery chains: competing and partnering
- Specialty hospitals within multi-hospital systems

Virtues of integrated, coordinated services and virtues of focused, specialized services

Service lines within diversified organizations
Medical Management and Wellness 2.0

- CDHP vision of self-directed care has faded, as insurer, employer, and government roles grow
  - Disease management for chronic conditions
  - Renewed interest in workplace wellness programs
  - Paternalistic incentives for healthy lifestyles
  - Increased interest in population-based approaches
    - Geographic variations in utilization, appropriateness, outcomes
    - Public health interventions for infectious disease
Managed Consumerism

- Insurance
  - Value-based benefits
  - High performance networks

- Delivery of care
  - The medical home
  - Payment incentives
  - Centers of excellence and service lines
High deductibles create too little coverage for low-cost, efficient services and too much coverage for high-cost, inefficient services

Value-based benefits:
- First dollar coverage for effective drugs
- First dollar coverage for preventive test, PCP visits
- Differential cost sharing for procedures, providers, sites of care according to value
Insurers and employers use data on prices, costs, outcomes to identify best performers
  - Create cost-sharing incentives for consumers
  - Work with providers to improve performance
    - Narrow networks or differential cost coinsurance
    - “Center of excellence” contracting for high-cost services

Provider organizations use data to self-analyze and self-improve, create high-performance organization
  - Virginia-Mason, Geisinger, Kaiser-Permanente
Chronic care accounts for majority of avoidable costs and treatable burdens of disease

- Coordination of care is essential
  - Electronic medical records
  - Primary care, non-physician providers, patient education
  - Payment methods other than FFS: capitation, episodes

- Much of chronic care is due to self-abuse by consumers
  - Giving them higher deductibles is not the answer
Payment Incentives

- Pay-for-Performance expands carefully
  - From commercial insurance to Medicare, Medicaid
  - From process to outcome measures of quality
  - From quality to value (quality and efficiency)

- Episode-of-illness payments
  - FFS undermines coordination, total-cost accountability
  - Episode pricing create incentive for provider integration

- Whispers of capitation 2.0
Hospital systems are restructuring internally to achieve the efficiencies of focus and specialization

- Service lines for health plan contracting, consumer branding, internal accounting and accountability
  - Orthopedics, cardiology, surgery, women’s health, neurology

Hospitals are developing specialty hospitals and ambulatory surgery/diagnostic centers in cooperation and/or competition with independents

This service-specific competition is healthy
# Managed Consumerism: Incentives for Patients and Incentives for Providers

<table>
<thead>
<tr>
<th>Use of Health Service is not Sensitive to Physician Supply and Incentives</th>
<th>Use of Health Service is not Consumer Demand-Sensitive</th>
<th>Use of Health Service is Consumer Demand-Sensitive</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Use of Health Service is not Sensitive to Physician Supply and Incentives</strong></td>
<td>“Medically necessary” Benefit incentives: mild Network incentives: mild</td>
<td>“Moral Hazard” Benefit incentives: strong Network incentives: mild</td>
</tr>
<tr>
<td>Appendectomy</td>
<td>Brand v. generic drug</td>
<td></td>
</tr>
<tr>
<td><strong>Use of Health Service is Sensitive to Physician Supply and Incentives</strong></td>
<td>“Supplier-induced demand” Benefit incentives: mild Network incentives: strong</td>
<td>“Discretionary care” Benefit incentives: strong Network incentives: strong</td>
</tr>
<tr>
<td>Selection of cardiac implant</td>
<td>Diagnostic radiology</td>
<td></td>
</tr>
</tbody>
</table>
### Managed Consumerism: Balancing the Virtues of Coordination and Specialization

<table>
<thead>
<tr>
<th>No Scale Economies in the Provision of Care</th>
<th>Acute Conditions</th>
<th>Chronic Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Retail Clinic”</td>
<td>Freestanding clinic for episodic primary and preventive care</td>
<td>“Medical Home” Multi-specialty medical group emphasizing continuity and coordination</td>
</tr>
<tr>
<td>Significant Scale Economies in the Provision of Care</td>
<td>“Service Line” Inpatient/outpatient facilities for surgeries where volume improves outcome, cost</td>
<td>“Center of Excellence” Multi-disciplinary centers with emphasis on specific conditions (e.g., oncology)</td>
</tr>
</tbody>
</table>
A New Ownership Society

- Rethinking the design of incentives
  - Benefits and networks
- Rethinking the organization of care
  - Coordination and specialization
- Rethinking sponsorship
  - Individual and community responsibility
Rethinking the Design of Incentives

- The high deductible health plan with HSA is ineffective, inefficient, and inequitable
  - Aside from that, it’s great
- FFS payment and retail pricing is inflationary, discriminatory, and distorts career and capacity choices
  - Aside from that, it’s great
- Cost sharing and low payments for low-value services
- Good coverage and high payments for high-value services
Rethinking the Organization 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
Rethinking Sponsorship

- 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
A New Ownership Society

- 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