A New Ownership Society in Health Care

Consumer-Driven Healthcare Summit
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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

Benefit Design 2.0

- 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

Network Design 2.0

- 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

Hospital Services 2.0

- 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

Value-Based Insurance Benefits

- 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

High-Performance Networks

- 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

The Medical Home

- 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

Service Lines

- 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

	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 Physician Supply and Incentives	"Medically necessary" Benefit incentives: mild Network incentives: mild Appendectomy	"Moral Hazard" Benefit incentives: strong Network incentives: mild Brand v. generic drug
Use of Health Service is Sensitive to Physician Supply and Incentives	"Supplier-induced demand" Benefit incentives: mild Network incentives: strong Selection of cardiac implant	"Discretionary care" Benefit incentives: strong Network incentives: strong Diagnostic radiology

Managed Consumerism: Balancing the Virtues of Coordination and Specialization

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

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