

## From Managed Care to Consumer Driven Health Plans

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## Rise of Managed Care

- Old model of health care delivery: fee for service
  - Provider reimbursed for all services provided
- All the wrong incentives
  - Asymmetric information – “induced demand”
  - Encourages overuse
  - What is one example we’ve already discussed that fits this general description?

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## Solution: Managed care

- Instead of reimbursing on a per procedure basis, pay physicians to handle all care associated with patient
- Pre-paid health care
  - First health insurance plan in US
- Archetypical model – health maintenance model (HMO)
  - HMO receive monthly reimbursement to provide care for insured

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- Reduce incentive for excessive care – HMO will eat cost of all care provided
- HMOs encouraged to provide certain types of care? Name a few?
- However – now the concern is that physicians have incentive to under provide care
- Key research question: quality vs. quantity of care

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## HMOs

- Provides care for enrolled patients for fixed fee per month
- HMO
  - assumes risk of over use.
  - has better incentive to monitor care
- Types
  - Group – collection of different groups provide all types of care
  - Staff model – HMO hires the Docs, can only see doc on staff.

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## Preferred provider organization (PPO)

- Coverage is provided to participants through a network of hospitals and physicians
- Providers receive fee for access to network – so combination of FFS and pre-paid
- Insurance company negotiates w/ providers over costs
- Enrolled can go outside the network, but at much higher costs
- Utilization review of provides

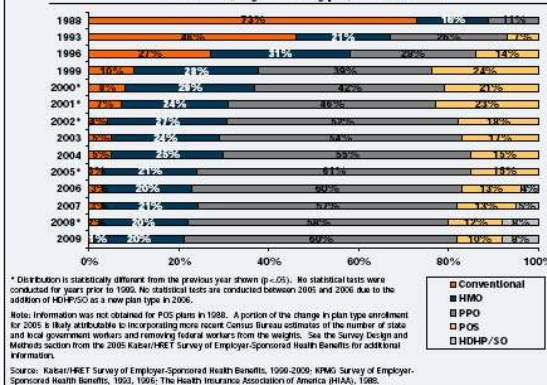
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## Point of Service

- Patients enroll with primary care physician (PCP)
  - They receive capitated payment for service
  - Act as gatekeeper –
- If PCP refers patient for additional care, must stay 'in network'
  - Out of network care has high coinsurance rates
- Strong utilization review – MDs hammered if too many referrals

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**Exhibit 5.1**  
Distribution of Health Plan Enrollment for Covered Workers, by Plan Type, 1988-2009



## Research questions

- Use of services?
- Prices?
- Quality of care (measurable outcomes)?
- Spillovers into non-managed care sector?

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### EXHIBIT 1 Quality-Of-Care Findings: HMOs Compared With Non-HMOs

Finding	Number of findings	Studies
F s	5	Cherniew et al. 1998; Escarce et al. 1999; Potosky et al. 1997
F s, ns	9	Every et al. 1998; Levinson and Ullman 1998; McCormick et al. 1999; Orosko et al. 1998; Orosko et al. 2000; Potosky et al. 1997; Riley et al. 1999; Shapiro et al. 1999; Soumerai et al. 1999; Spetz et al. 2001
F/M s, ns	0	
F ns	2	Kreindel et al. 1997; Lee-Feldstein et al. 2000
Mixed	4	Kelcher et al. 1997; Obst et al. 2001; Roetzheim et al. 2000 (Cancer); Roetzheim 1999
Same	9	Holtzman et al. 1998; Levinson et al. 1998; Merrill et al. 1999; Oleske et al. 2000; Philbin et al. 1998; Picken et al. 1998; Ray et al. 1998; Retchin et al. 1997 (9 July); Spetz et al. 2001
UF ns	3	Escarce et al. 1999; Lee-Feldstein et al. 2000; Mukamel et al. 2000
UF/M s, ns	2	Retchin 1997b; Roetzheim et al. 2000; Roetzheim 1999
UF s, ns	5	Experton et al. 1999; Guadagnoli 2000; Ni et al. 1998; Roetzheim et al. 2000 (Cancer); Roetzheim 1999; Sada et al. 1998
UF s	0	Erickson 2000 (19 April); Erickson 2000 (June); Escarce et al. 1999; Hadley and Mitchell 1997; Potosky et al. 1999; Schwartz et al. 1998; Smith et al. 1999
Total	47	

SOURCES: Peer-reviewed literature, 1997 through mid-2001. See endnotes in text.  
NOTE: For an explanation of the findings codes, see text.

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Fairly even distribution of Favorable and unfavorable Results for specific diseases

### EXHIBIT 2 Quality-of-Care Findings, By Disease/Condition Category, HMOs Compared With Non-HMOs

Finding	Cancer		Heart		Other	
	Number of Findings	Studies	Number of Findings	Studies	Number of Findings	Studies
F s	1	Potosky et al. 1997	4	Cherniew et al. 1998; Escarce et al. 1999	0	
F s, ns	2	Potosky et al. 1997; Riley et al. 1999	3	Every et al. 1998; McCormick et al. 1999; Soumerai et al. 1999	4	Levinson and Ullman 1998; Orosko et al. 1998; Shapiro et al. 1999; Spetz et al. 2001
F ns	1	Lee-Feldstein et al. 2000	1	Kreindel et al. 1997	0	
Mixed	2	Roetzheim et al. 2000 (Cancer); Roetzheim 1999	0		2	Kelcher et al. 1997; Obst et al. 2001
Same	1	Merrill et al. 1999	2	Philbin and D'Elia 1998; Posen et al. 1998	6	Holtzman et al. 1998; Levinson and Ullman 1998; Orosko et al. 2000; Ray et al. 1998; Retchin et al. 1997 (9 July); Spetz et al. 2001
UF ns	1	Lee-Feldstein et al. 2000	2	Escarce et al. 1999; Mukamel 2000	0	
UF/M s, ns	2	Retchin et al. 1997 (9 July); Roetzheim et al. 2000 (Cancer); Roetzheim 1999	0		0	
UF s, ns	1	Roetzheim et al. 2000 (Cancer); Roetzheim et al. 1999	3	Guadagnoli et al. 2000; Ni et al. 1998; Sada et al. 1998	1	Experton et al. 1999
UF s	2	Hadley and Mitchell 1997; Potosky et al. 1999	4	Erickson et al. 2000 (19 April); Erickson et al. 2000 (June); Escarce et al. 1999	2	Schwartz et al. 1998; Smith et al. 1999
Total	13		19		15	

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### EXHIBIT 5 Satisfaction Findings: HMOs Compared With Non-HMOs

Finding	Number of findings	Studies
Same	2	Roche et al. 1997; Long and Coughlin 2001
UF ns	1	Newacheck et al. 2001
UF/M s, ns	2	Reschovsky et al. 2000; Safran et al. 2000; Tudor et al. 1998
UF s, ns	3	Flora 1998; Safran et al. 2000
UF s	2	Gawance et al. 1998; Sh 2000
Total	11	

Clear pattern on satisfaction and preventative services

### EXHIBIT 6 Prevention Findings: HMOs Compared With Non-HMOs

Finding	Number of findings	Studies
F s, ns	7	Carrasquillo et al. 2001; Gordon et al. 1998; Potosky et al. 1998; Reschovsky et al. 2000; Weinick and Beauregard 1997
F ns	1	Phillips et al. 1998
Same	1	Alessandri et al. 2001
UF ns	1	Newacheck et al. 2001
Total	10	

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### Miller and Luft

- *Compared with non-HMOs, HMOs had roughly comparable quality of care, more prevention activities, less use of hospital days and other expensive resources, and lower access and satisfaction ratings.*
- ***Here is the kicker***

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- *“In a majority of with direct HMO versus non-HMO comparisons, HMO enrollees either were younger or had a pattern of somewhat fewer co-morbidities. In general, the studies we included attempted to control for such differences, but such controls may be inadequate...”*

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### Current system of health insurance

- Provided primarily by EPHI
  - Encourages too generous health insurance
  - Generates horizontal and vertical tax inequality
- Level of health insurance coverage must balance
  - Benefits of income smoothing
  - Costs of moral hazard
- Two goals of health reform: equity and efficiency (could be many other goals)

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### Reaction by some

- Growing dissatisfaction with managed care in some quarters
- Consumers have limited ‘choice’
  - Choice of physicians/hospitals
  - System set up to restrict demand for care
  - Restricted by HMO/gatekeeper in access to specialist

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- Produce call for consumerism on part of those with insurance
  - Patients needed greater choice
- Strange bedfellows
  - Liberals felt managed care prevented single payer
  - Conservatives found managed care anti consumer
- How do you provide
  - Choice for consumers?
  - Without costs of moral hazard?

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## Pauly and Goodman

- Replace tax preferred delivery of EPHI with tax credits
- Catastrophic coverage for unpredictable but large expenditures
- Medical Savings Accounts (MSA) for small expenditures

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## MSA

- Began by act of congress in 1996 (HIPPA).
- Combine high deductible health insurance with a savings account
- Individuals make deposits to designed health savings account and make withdraws for routine care
  - Deposits can be made by firm for workers
  - Deposits can be made in before tax dollars
  - Can rollover savings from year to year

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- Must be paired with a catastrophic plan to maintain coverage for large expenses
- Initially restricted to self-employed and employees of small firms
- Extended to all employers in 2003. Redefined as Archer Health Savings Accounts (HSAs)
- For 2009 maximum annual contributions to HSA are \$3000/\$5950 for single/family.

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- If firm makes payments to an account and a worker withdraws for medical expenses, called Health Reimbursement Arrangements (HRA)
- If worker makes the deposits, called HSA

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### Catastrophic plans

- Now called High Deductible Health Plan (HDHP)
- Much higher deductible than in other plans but more generous coverage once a family meets the stop-loss provision.
- Because coverage is less extensive, premiums are also much lower.

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Exhibit 8.6  
HDHP/HRA and HSA-Qualified HDHP Features for Covered Workers, 2009

Annual Plan Averages for:	HDHP/HRA		HSA-Qualified HDHP	
	Single	Family	Single	Family
Premium	\$4,274	\$12,223	\$3,829	\$10,396
Worker Contribution to Premium	\$734	\$3,067	\$438	\$2,453
General Annual Deductible <sup>1</sup>	\$1,690	\$3,422	\$1,922	\$3,734
Out-of-Pocket Maximum Liability <sup>1</sup>	\$3,035	\$6,441	\$2,976	\$5,842
Firm Contribution to the HRA or HSA <sup>5</sup>	\$1,052	\$2,073	\$688	\$1,126

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Exhibit 1.1  
Average Monthly and Annual Premiums for Covered Workers, Single and Family Coverage, by Plan Type, 2009

	Monthly	Annual
<b>HMO</b>		
Single Coverage	\$406	\$4,878
Family Coverage	\$1,123	\$13,470
<b>PPO</b>		
Single Coverage	\$410	\$4,922
Family Coverage	\$1,143	\$13,719
<b>POS</b>		
Single Coverage	\$403	\$4,835
Family Coverage	\$1,090	\$13,075
<b>HDHP/ISO</b>		
Single Coverage	\$332*	\$3,986*
Family Coverage	\$924*	\$11,083*
<b>ALL PLAN TYPES</b>		
Single Coverage	\$402	\$4,824
Family Coverage	\$1,115	\$13,375

\* Estimate is statistically different from All Plans estimate (p<.05).

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009.

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Exhibit 7.11 Among Covered Workers with a General Annual Health Plan Deductible, Average Deductibles for Family Coverage, by Deductible Type, Plan Type, and Firm Size, 2009		
	Aggregate Amount	Separate Amount per Person
<b>HMO</b>		
All Small Firms (3-199 Workers)	NSD	NSD
All Large Firms (200 or More Workers)	\$1,089	\$600
<b>ALL FIRM SIZES</b>	<b>\$1,524</b>	<b>\$686</b>
<b>PPO</b>		
All Small Firms (3-199 Workers)	\$2,596*	\$904*
All Large Firms (200 or More Workers)	1,077*	527*
<b>ALL FIRM SIZES</b>	<b>\$1,488</b>	<b>\$633</b>
<b>POS</b>		
All Small Firms (3-199 Workers)	\$2,566*	NSD
All Large Firms (200 or More Workers)	1,387*	\$841
<b>ALL FIRM SIZES</b>	<b>\$2,191</b>	<b>\$1,050</b>
<b>HDHP/SO</b>		
All Small Firms (3-199 Workers)	\$4,037*	NSD
All Large Firms (200 or More Workers)	3,258*	\$1,973
<b>ALL FIRM SIZES</b>	<b>\$3,626</b>	<b>\$2,091</b>

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Exhibit 7.3 Among Covered Workers with a General Annual Health Plan Deductible for Single Coverage, Average Deductible, by Plan Type and Firm Size, 2009	
	Single Coverage
<b>HMO</b>	
All Small Firms (3-199 Workers)	\$900*
All Large Firms (200 or More Workers)	528*
<b>ALL FIRM SIZES</b>	<b>\$699</b>
<b>PPO</b>	
All Small Firms (3-199 Workers)	\$1,040*
All Large Firms (200 or More Workers)	478*
<b>ALL FIRM SIZES</b>	<b>\$634</b>
<b>POS</b>	
All Small Firms (3-199 Workers)	\$1,268
All Large Firms (200 or More Workers)	695
<b>ALL FIRM SIZES</b>	<b>\$1,061</b>
<b>HDHP/SO</b>	
All Small Firms (3-199 Workers)	\$2,037*
All Large Firms (200 or More Workers)	1,642*
<b>ALL FIRM SIZES</b>	<b>\$1,838</b>

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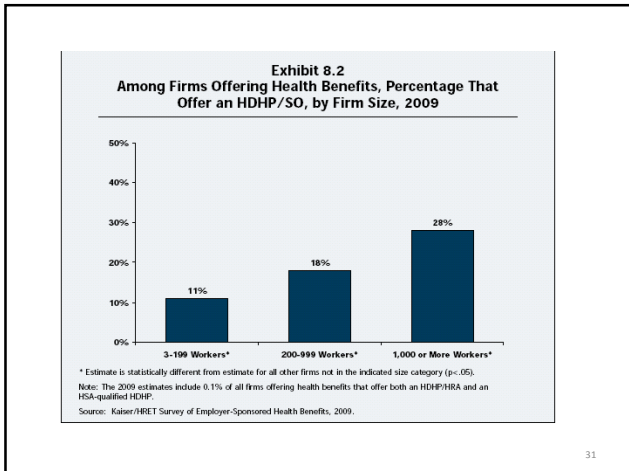
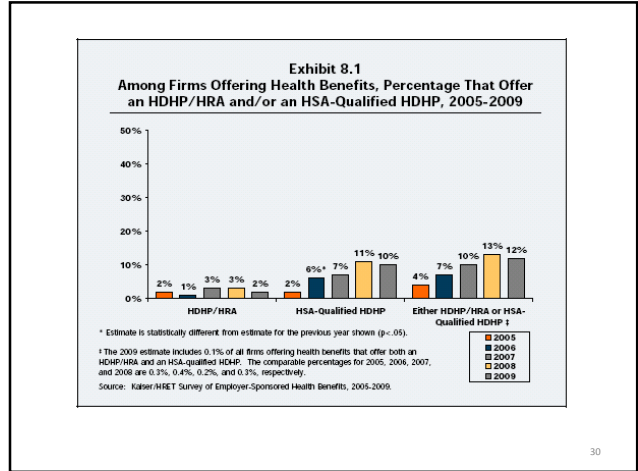
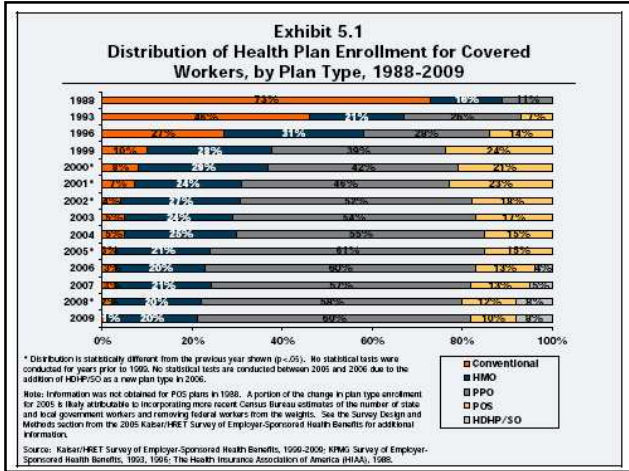
## Benefits

- Catastrophic coverage satisfies the income smoothing benefits of insurance
  - Closer to economic ideal of insurance
  - Ability to choose higher deductibles for lower premiums encourages families to hold down spending
- Lessens distortion of moral hazard
  - Increased coinsurance for more routine care
  - Consumers not consider costs of care when making health service decisions

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- Reduces tax inequality
  - Tax benefits available to those without EPHI
  - Because the fixed credit is available for those with “qualified” packages, does not distort price of insurance

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Why is most likely to enroll in a CDHP?

■ Table 1. Characteristics of Respondents by Plan Type in 2004\*

Characteristic	All (N = 1316)	CDHP (n = 973)	PPO (n = 343)
Male	60.3	60.1	60.6
<b>Education<sup>b</sup></b>			
High school graduate or less	35.7	32.5	45.0
Some college or vocational school	35.2	34.9	36.1
College graduate or more	29.1	32.6	18.9
<b>Annual income<sup>b</sup></b>			
<\$25,000	5.1	4.4	7.1
\$25,000-\$49,999	38.4	36.4	44.0
≥\$50,000	55.6	59.2	40.5
<b>Marital status: married</b>	71.5	73.6	70.7
<b>Age, y<sup>b</sup></b>			
22-35	11.9	12.6	9.6
36-50	42.6	45.7	33.5
51-62	45.6	41.6	56.9
<b>Self-reported health very good or excellent<sup>b</sup></b>	50.3	53.3	41.4
<b>Hourly employee<sup>b</sup></b>	52.8	49.2	63.0
<b>Average patient activation score<sup>c</sup></b>	64.1	64.6	62.8

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■ Table 3a. Percentage of Consumers With Higher Activation Scores Who Did or Did Not Engage In Behaviors in 2004\*

Behavior	CDHP (n = 954)			PPO (n = 328)		
	No (%)	Yes (%)	P	No (%)	Yes (%)	P
<b>Information-seeking</b>						
Used any Web site for health information						
Higher activation score <sup>b</sup>	44.4	61.3	<.001	37.2	55.3	<.01
Used a telephone advice nurse or health coach						
Higher activation score <sup>b</sup>	51.4	58.6		27.2	61.2	<.001
Was persistent in asking doctor to explain something until understood						
Higher activation score <sup>b</sup>	35.6	83.7	<.001	28.6	49.2	
<b>Healthy</b>						
Limited fat in diet						
Higher activation score <sup>b</sup>	41.3	62.7	<.001	41.8	45.1	
Exercised regularly						
Higher activation score <sup>b</sup>	41.4	62.5	<.001	43.4	43.5	
Five or more servings of fruits/vegetables a day						
Higher activation score <sup>b</sup>	46.3	63.3	<.001	41.4	48.1	

CDHP indicates consumer-driven health plan; PPO, preferred provider organization.  
<sup>a</sup>Statistical differences in Patient Activation Measure scores were tested within the plan design by <sup>2</sup>test.  
<sup>b</sup>Scored in the upper 50% of respondents on the Patient Activation Measure.

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## McKinsey Survey

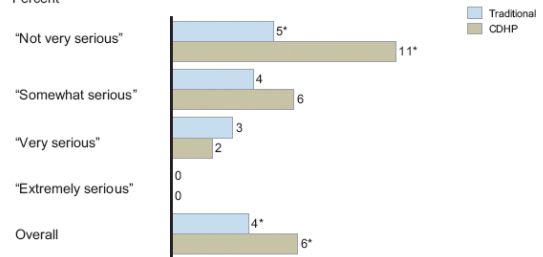
- 1000 people nationwide
- Two types of respondents
  - People in traditional managed care plan
  - Those whose company switched all employees to CDHP one year ago. Why this group?

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### Exhibit 1

#### CDHP MEMBERS SELF-REPORT LOWER UTILIZATION FOR LESS SERIOUS CONDITIONS

Patients forgoing all care by perceived seriousness of health issue  
Percent



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