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# Managed Consumerism In Health Care

A new vision for pursuing public ends through private means.

by James C. Robinson

**ABSTRACT:** The future of market-oriented health policy and practice lies in "managed consumerism," a blend of the patient-centric focus of consumer-driven health care and the provider-centric focus of managed competition. The optimal locus of incentives will vary among health services according to the nature of the illness, the clinical technology, and the extent of discretion in utilization. A competitive market will manifest a variety of comprehensive and limited benefit designs, broad and narrow contractual networks, and single- and multispecialty provider organizations.

For proponents of market-oriented health care, these are the best of times and the worst of times. The U.S. health care market supports the world's most dynamic life sciences industry, contributes to major improvements in longevity and life quality, and enjoys the support of a president firmly committed to private-sector solutions. But two decades of experimentation with market mechanisms have not been able to ensure universal access to care; eliminate unjustified variability in quality and efficiency; or forestall a backlash against health maintenance organizations (HMOs), investor ownership, and many other features of the private-sector approach. Managed competition, the conceptual framework that once dominated the market approach, has been battered by employers' retreat from active engagement in health system reform and by the financial turmoil besetting physician and hospital organizations.[1] A "consumer-driven" framework has emerged to promote choice and competition while reducing the roles of employers, insurers, and integrated delivery systems (IDSs).[2]

To some extent, the managed competition and consumerist frameworks merely focus on different parts of the same elephant, with the former highlighting problems of information, coordination, and incentives in the supply of clinical services and the latter focusing on analogous problems in demand. Philosophically, however, consumerism challenges several core tenets of managed competition and would replace it with a new vision and method for pursuing public ends through private means.

This paper analyzes the consumerist challenge to managed competition as the

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market approach to health care, highlighting their commonalities and their divergences. It promotes consumerism as the framework that relies least on unreliable purchaser and provider organizations but insists on the acuity of the managed competition insight that markets need institutional supports. It begins the work of reconciling the two feuding factions by emphasizing the importance of demand-side, consumer-focused incentives for some clinical services and of supply-side, provider-focused incentives for others. Turning from health insurance to health care delivery, the paper then highlights the virtues of different forms of organization and payment for alternative forms of care, arguing that consumerism and managed competition often are proposing different solutions to different problems, not different and incompatible solutions to the same problems.

## Consumerism Versus Managed Competition?

Consumerism and managed competition share the market paradigm that social resources, including medical care, should be allocated based on individual rather than collective decisions. Informed and price-conscious individual choices represent the values and preferences of the patient better than the choices of even the most benevolent third party. The performance of the delivery system is enhanced by consumer and provider incentives that align the pursuit of individual self-interest with the social interest in promoting a high-quality, cost-effective system of care. Collective-choice mechanisms such as regulatory agencies, professional associations, and corporate organizations find their utility in supporting, and their disutility in displacing, individual choices.

The core of medical care, the clinical encounter between patient and physician, is beset by the uncertainties of illness and therapy, the social imperative to subsidize care for those unable to pay, and the proclivity of patients to demand more services if someone else is paying and for physicians to adjust their supply depending on how they are paid. Choice and competition in the clinical context therefore need to be embedded in a larger institutional framework, similar to that for insurance coverage, where benefit and network designs specify the consumer's and the collectivity's financial responsibilities and create incentives for balancing cost, quality, and other service characteristics. Exhibit 1 presents, in schematic form, the perspectives of consumerism and managed competition concerning the markets for health care and health insurance. To facilitate insight into each framework, emphasis is placed on areas of divergence rather than areas of convergence; most actual proposals are nuanced and borrow elements from each framework.

As variants on the market-oriented approach to health policy, both consumerism and managed competition must be broadly positive concerning patients' ability to make choices that, in turn, generate pressures for increased quality and efficiency among providers and insurers. However, the two frameworks differ greatly in their views as to the appropriate locus for consumer choice and, in particular, for consumer-centric financial incentives.

**EXHIBIT 1**
**Contrasting Views Of Consumerism And Managed Competition On The Markets For Health Care And Health Insurance**

| Market for health care | Consumerism | Managed competition |
|---|---|---|
| Physician-patient interaction | Price-conscious consumer choice generates appropriate provider behavior | Practice variations, quality shortfalls result from weak consumer choices |
| Large physician and hospital organizations | Often bureaucratic, monopolistic | Source of coordination, incentive alignment |
| Preferred practice setting | Small physician practices, single-specialty hospitals | Multispecialty medical groups, integrated delivery systems |
| Preferred provider payment method | Fee-for-service, episode-of-illness pricing | Capitation for provider organizations, salary for individual physicians |
| Preferred method of performance measurement | Performance measures of individual physicians and clinical services | Performance measures of physician organizations and the spectrum of services |
| Role of economic incentives at time of seeking care | Central: with substantial cost sharing, consumer faces strong incentive to consider cost as well as quality | Peripheral: with limited cost sharing, consumer focuses on quality rather than cost |
| **Market for health insurance coverage** | | |
| Health insurance plans | Skeptical: Insurance is needed to spread risk, but it fosters price-unconscious demand | Positive: Support consumer choice and provider coordination, as well as spreading risk |
| Preferred benefit design | Extensive consumer cost sharing: high deductible with health savings account | Limited consumer cost sharing: comprehensive coverage with modest copayments |
| Preferred network design | Broad PPO network with competing, nonintegrated providers | Integrated HMO network, ideally centered on physician group practices |
| Role of employer and governmental sponsors as active purchasers of insurance coverage | Skeptical: Third parties distort consumer incentives; ideal is individual insurance market with tax subsidies | Positive: Sponsors need to play active role in comparing quality, offsetting risk selection, and not merely subsidize coverage |
| Role of economic incentives at time of choosing insurance coverage | Peripheral: health plans should offer similar, overlapping provider networks; consumer has choice focused on benefit design, not network design | Central: health plans should offer distinct, competing provider networks; consumer choice focused on network design, not benefit design |

**SOURCE:** Author's analysis.
**NOTES:** PPO is preferred provider organization. HMO is health maintenance organization.

The most fundamental difference between the two frameworks lies in their views of consumers' ability to make appropriate choices at the time of seeking medical care, and, consequently, their views of the utility of organizations that inform, subsidize, and guide individual choices.

■ **Consumers' cost and quality choices.** Consumerism holds an optimistic view of consumers' ability to make cost- and quality-conscious choices at the time of seeking care and is skeptical concerning the role of intermediary organizations such as physician groups and hospital systems, vertically integrated health plans, and corporate purchasers of health benefits. The managed competition framework, on

the other hand, is skeptical concerning patients' ability to make good financial decisions at the time of illness and shifts the locus of incentives to a less emotionally charged setting. Managed competition is broadly favorable to organizations that coordinate the many clinical and financial dimensions of health care, interpreting them as important supports for, not replacements to, consumer choice. Managed competition tends to see the consumer-choice process as occurring in two steps, with the first step being selection among provider systems and the second step, selection among practitioners within those systems.

■ **Role of intermediary organizations.** The divergence in views concerning consumers' cognitive abilities and the role of intermediary organizations generates sizable differences in how consumerism and managed competition view each major component of the health care delivery system (top half of Exhibit 1). Managed competition tends to hold a favorable view of multispecialty groups as the best structure of physician practice, providing the coordination and culture to manage the clinical continuum, whereas consumerism tends to favor focused provider organizations that achieve scale efficiencies through specialization.

■ **Provider payment and performance measurement.** Consistent with this divergence in organizational preferences, consumerism tends to highlight fee-for-service or episode-of-illness (case rate) payment, as consistent with independent, à la carte choice among providers at the time of care. Managed competition tends to highlight prospective capitation payment as consistent with choice among organized systems for a defined period of time. (For managed competition, capitation ideally is used to pay provider systems, whereas individual physicians are paid on a salaried basis.) Also, consumerism tends to highlight performance measurement at the level of the individual clinician or service, whereas managed competition tends to highlight measurement at the level of the group practice or system of care.

■ **Role for health plans.** The divergent views of consumerism and managed competition concerning patients' ability to navigate the market for health care services creates a divergence in their views of the appropriate role for health insurance plans (bottom half of Exhibit 1). Most fundamentally, consumerism is skeptical concerning the role of health plans that actively structure consumer choices. Health insurance is viewed as socially beneficial for the purpose of spreading the costs of unpredictable illness and treatment but as undermining consumers' cost-conscious choice among providers and procedures. The optimal insurance benefit design, from the consumerist perspective, is the high-deductible indemnity umbrella, supported by a health savings account (HSA) from which the consumer pays for noncatastrophic medical expenses. Narrow provider networks and protocol-based utilization management interfere with consumers' ability to independently select among the full range of providers and procedures at the time of seeking care, and hence are to be avoided.

Managed competition's perspective on active care management by health insurance is quite different. Health plans are viewed positively to the extent that they

get involved in the clinical context by structuring selective provider networks and promoting evidence-based clinical protocols. Insurers that adopt a hands-off indemnity approach, passively reimbursing any willing provider and any recommended treatment, are viewed as sources of excess demand rather than efficiency. Managed competition highlights the uneven distribution of medical expenditures, where the vast majority of costs are incurred by a small minority of very ill patients, and infers that financial incentives should be directed primarily at providers rather than consumers.[3] The ideal benefit package for managed competition is comprehensive, covering preventive, acute, chronic, and behavioral services and imposing only modest copayments at the time of care. To the extent possible, health plans should offer distinct, nonoverlapping physician networks that can compete with one another on the basis of cost, quality, and access.

## Reconciling Consumerism And Managed Competition

Health insurance plans have weakened or abandoned many of the design features they implemented during the period in which managed competition was the dominant market-oriented conceptual framework, including primary care referrals to specialty consultations, prior authorization for tests and procedures, and administrative limits on hospital admissions and lengths-of-stay. The recent reignition in health care cost inflation has spurred interest among employers in consumer-driven product designs, resulting in substantial growth in copayments for physician services, a shift from dollar copayments to percentage coinsurance, the imposition of cost sharing for inpatient and ambulatory surgery, a conversion from HMO product designs that generally do not permit annual deductibles to preferred provider organization (PPO) product designs that do, and, most recently, "consumer-driven health plans" that feature high-deductible catastrophic coverage and HSAs for routine services.[4]

As health care costs continue to rise at rates well above the rate of growth in economic productivity and earnings, however, health plans likely will combine their current demand-side, consumer-centric incentives with their erstwhile supply-side, provider-centric incentives to staunch the abandonment of insurance coverage by employers and employees.[5] Second-generation consumer-driven products feature disease management and case management programs for patients with chronic and catastrophic conditions, subnetworks or "tiers" of providers who charge lower fees, centers-of-excellence programs for complex surgeries, and variable cost sharing across alternative settings of care. These and other emerging features permit consumers to stretch their HSAs and out-of-pocket payments through choices that take cost as well as quality into consideration. It is not hard to envisage high-deductible, narrow-network, tightly managed product designs where choice of providers and procedures is limited by consumers themselves in favor of affordability.

Ever-higher consumer cost sharing and ever-tighter provider networks would

threaten the efficiency and equity of the health care delivery system. Excessive consumer cost sharing reduces the social pooling of risk, transferring financial responsibility from the healthy to the sick, and potentially reduces efficiency by reimbursing episodic and acute care services more generously than preventive and chronic care services. Excessively narrow provider networks frustrate patients' ability to match their preferences with provider characteristics and limit providers' ability to compete broadly on the basis of price and quality at the time of care. Instead of merely combining blunt consumer cost-sharing incentives with blunt provider network incentives, an efficient health insurance system would modulate incentives according to the nature of particular clinical services. New benefit and network designs would, in turn, foster change in the organization of clinical care, with different forms of care provided in different settings that are reimbursed using different methods.

## The Market For Insurance Coverage

Market-oriented health policy highlights the role of incentives in generating appropriate behavior on both the demand and the supply sides of the medical marketplace, among both consumers and providers. Although consumers will use some forms of care without regard to cost, much of contemporary medicine is composed of tests and treatments with an extensive discretionary component, and most studies of care-seeking report a considerable sensitivity to patients' out-of-pocket payments.[6] Similarly, although some forms of care will be provided by all physicians to all patients with a particular condition, without regard to form of reimbursement, the contemporary landscape exhibits wide variability in physicians' practice patterns and a strong responsiveness to whether hospital bed capacity is high or low and to whether providers are paid prospectively or retrospectively.[7]

■ **Demand-side incentives.** Demand-side incentives are embodied in benefit designs that strive to balance the virtues of protecting consumers from unforeseen medical care expenditures, on the one hand, with those of stimulating cost-conscious consumer choice, on the other.[8] The general principle holds that cost sharing should be fostered most extensively for services that are discretionary and sensitive to patients' preferences and minimized for services that are nondiscretionary and not sensitive to preferences. (Cost sharing also should be minimized for services that consumers tend to underuse even though they provide extensive social benefits, such as some preventive procedures.) The economic analysis of insurance highlights the optimal mix of coverage and cost sharing and the incentive effects of deductibles, fixed-dollar copayments, fixed-percentage coinsurance, and coverage exclusions.

■ **Supply-side incentives.** Supply-side incentives are embodied in insurance network designs, including the breadth and contractual structure of the provider relationships, the form of provider payment, and the administrative oversight mechanisms. Network designs seek to balance the virtues of reimbursing providers ade-

quately to promote quality and innovation, on the one hand, with those of motivating them to search for more efficient and less costly forms of treatment, on the other. The general principle holds that payment and administrative mechanisms should be incentive-oriented and "high powered" for services that exhibit considerable sensitivity to provider supply and payment. Network designs should be passive and "low powered" for services where providers have less discretion to adjust the quantity and quality of care according to how they are organized and paid. For example, prospective payment methods create incentives for the efficient use of resources but expose providers to the financial risks of attracting especially sick patients. They are best used where practice patterns are sensitive to provider supply, training, and reimbursement, whereas retrospective payment methods are best used where physicians' discretion is limited.

■ **Patient preference–sensitive care.** Reconciliation between the consumerist and managed competition perspectives would match incentive mechanisms with forms of care according to their responsiveness to providers' and patients' discretion. This could build on the research that categorizes clinical interventions as patient preference–sensitive, provider supply–sensitive, both, or neither and highlights the corresponding geographic variability in utilization.[9] Exhibit 2 identifies the optimal benefit and network designs, in highly schematic form, for each of the four types of care. Services in the upper-left quadrant of the exhibit are "medically necessary" in the sense that their use is driven by epidemiology and evidence-based interventions without regard to provider supply and patient preferences. The optimal benefit and network designs are low powered, as neither physicians nor patients should be exposed to financial risk for services for which they exercise no discretion. Rather, the cost of these services should be spread broadly over the entire population through comprehensive insurance.

Preference-sensitive services, where the demand for care is highly influenced by patient characteristics, are highlighted in the upper-right quadrant of Exhibit 2. The optimal insurance design for preference-sensitive care includes consumer

**EXHIBIT 2**
**Health Insurance Benefit And Network Designs For Particular Forms Of Medical Care**

| | **Demand not sensitive to consumer incentives such as cost sharing (benefit design)** | **Demand very sensitive to consumer incentives such as cost sharing (benefit design)** |
|---|---|---|
| **Demand not sensitive to provider incentives such as payment method** | "Medically necessary"<br>Benefit incentives: mild<br>Network incentives: mild | "Moral hazard"<br>Benefit incentives: strong<br>Network incentives: mild |
| **Demand very sensitive to provider incentives such as payment method** | "Supplier-induced demand"<br>Benefit incentives: mild<br>Network incentives: strong | "Discretionary care"<br>Benefit incentives: strong<br>Network incentives: strong |

**SOURCE:** Author's analysis.

cost sharing at the time of seeking care, as emphasized in the economic theory of insurance and reemphasized by advocates of consumer-driven health care. To the extent that the forms of care in the upper-right quadrant are not influenced by provider supply and payment, there are no grounds for incentive-conscious network designs. These preference-sensitive but supply-insensitive services are well covered by thin-benefit but broad-network insurance products of the form favored by consumerist critics of managed competition.

■ **Supply-sensitive services.** For supply-sensitive services, where the volume, mix, and intensity of care are influenced by the number of physicians, the capacity of hospital facilities, and the structure of provider payments, the optimal form of insurance moves from the upper to the lower half of Exhibit 2. Services that are sensitive to provider characteristics but not to patients' preferences are featured in the lower-left quadrant. Although it is difficult to conceptualize services that are fully independent of patient preference, the extensive list of services that vary according to provider capacity and payment method, documented by the *Dartmouth Atlas of Health Care* and the literature on "supplier-induced demand," fall into this category.[10] The focus of managed competition was on these services, as were earlier regulatory initiatives such as state certificate-of-need and hospital rate setting. The optimal insurance structure for these services would emphasize network design incentives, including tightly integrated provider networks, and administrative mechanisms such as prior authorization.

■ **Both patient- and provider-sensitive.** Health care services that are highly sensitive to both patient and provider characteristics (lower-right quadrant of Exhibit 2) are the most distinct from the "medically necessary" services that are traditionally conceptualized as candidates for insurance coverage and are most similar to out-of-pocket, noninsured services such as over-the-counter medications and vitamins. The optimal insurance design for these services includes strong incentives on both the demand and the supply sides of the market, implying high consumer cost sharing and strong cost-reducing incentives for providers. Employers and insurers have developed networks of providers and services that are not covered by insurance but that are offered to enrollees at discounted prices. Discounts on noninsured services constitute an element of network design because they are available only from providers who have contracted with health plans, offering lower prices and other concessions in exchange for higher patient volume. The most prominent examples include discount cards for prescription drugs, but the use of discounted networks has also increased for complementary medicine, durable medical equipment, and other services. Patients' access to services underneath a deductible, whether financed out of an HSA or taxable income, constitutes the use of discounted but noninsured services. As the prevalence and levels of deductibles rise in many insurance products, the importance of access to network discounts is growing.[11]

## The Market For Clinical Care

Managed competition and consumerism each offer helping hands to the invisible hand, proposing organizational, contractual, and regulatory structures to improve information, align incentives, and increase the efficiency of care. But if the two streams of market theory share an appreciation of the value and the fragility of health care markets, they also share a tendency to extrapolate from one form of care and the corresponding institutional framework to all forms of care and all institutional settings. The core insight of the larger body of institutional economics, however, is that the optimal forms of organization, contract, and regulation vary according to the characteristics of the underlying tasks and transactions.[12] The role of social analysis, in this perspective, is to identify the salient dimensions according to which tasks and transactions vary, the salient performance dimensions of alternative forms of organization, and the appropriate matching between particular tasks and particular forms of organization.

The many medical tasks that exist defy simple categorization, but, as a first approximation, they can be classified in terms of the acute versus chronic nature of each illness and by the presence or absence of scale and learning-curve efficiencies in the clinical intervention. Some clinical technologies exhibit very strong scale and learning-curve efficiencies, in which the quality and cost-effectiveness are especially good for providers with large caseloads, but many routine treatments exhibit few scale effects and are well provided by generalist clinicians.

Exhibit 3 describes alternative institutional structures according to where particular medical care services are located along the two dimensions of illness and clinical technology, highlighting the differing perspectives of managed competition and consumerism. The upper-left quadrant features acute care services that do not exhibit scale effects, such as routine preventive and primary care services,

**EXHIBIT 3**
**Alternative Forms Of Provider Organization, According To The Epidemiological And Technological Characteristics Of Health Care**

| | Epidemiology: acute conditions | Epidemiology: chronic conditions |
|---|---|---|
| **No significant scale and experience efficiencies in clinical technology** | "Minute clinic" Free-standing or retail-based drop-in clinics for episodic primary care (such as vaccination) | "Medical home" Multispecialty medical groups emphasizing continuity and coordination of services (such as diabetes care) |
| **Significant scale and experience efficiencies in clinical technology** | "Centers of excellence" Hospitals for complex surgery where high volume improves outcome (such as organ transplantation) | "Focused factory" Multidisciplinary centers with emphasis on specific conditions (such as oncology) |

**SOURCE:** Author's analysis.

and notes that "minute clinic" and other small-scale settings can provide adequate quality at lower cost than the fully integrated settings preferred by managed competition. However, as the nature of the illness becomes chronic and complex, moving the discussion from the upper-left to the upper-right quadrant of Exhibit 3, this doc-in-a-box model yields pride of place to what might be designated the "medical home"—the integrated, continuous relationship between a primary care physician and a supportive system of services, often structured through a multispecialty group practice.

The lower row of Exhibit 3 highlights alternative organizational frameworks for medical services that manifest large efficiencies of scale and experience. Acute conditions that benefit from high throughput to generate better outcomes and lower costs, such as organ transplantation and many forms of complex surgery, are best referred to regional centers of excellence (lower-left quadrant).[13] The salient feature of many centers of excellence, however, is their geographic distance and only arm's-length link with the patient's usual source of care. For chronic conditions, this fragmentation is dysfunctional, and the need grows for settings that are geographically accessible, can treat multiple conditions, and are coordinated with community and family sources of support. The multispecialty medical group offers such an institutional framework, as argued by proponents of managed competition, and the regionalization of high-cost acute services was pioneered by large delivery systems. Most U.S. communities do not support clinical enterprises large enough to achieve efficiencies of scale and experience across all diagnoses and forms of care, although the hub-and-spoke systems developed by the Mayo Clinic and other predominantly rural health systems prove that population density is not a prerequisite for organizational coordination.

The term "focused factory" was coined to designate high-volume but single-specialty or -condition settings that achieve volume efficiencies (in contrast to the medical home) yet offer continuous care (in contrast to the center of excellence) (Exhibit 3).[14] It is unclear whether the focused-factory model can be effective for chronic conditions such as diabetes and not merely for acute services such as hernia repair. Many chronic conditions are accompanied by comorbidities and are influenced by behavioral, family, and community factors that suggest that they are best integrated with the full continuum of services (that is, the medical home). However, oncology and HIV treatments, which extend over considerable periods and involve extensive comorbidities, often are well provided by specialized entities and need not be organizationally integrated with the patient's usual source of primary care (they do need to be integrated in terms of information exchange).

## Concluding Remarks

This is the moment for a second generation of consumer-driven health policies and products. The shortcomings of HMOs, capitation, IDSs, and the other components of managed competition have opened the way for alternative approaches to

using market mechanisms for improving the health care system.[15] Consumerism appeals to the widespread and legitimate desire for a more transparent, flexible, and personal system and provides a salutary counterbalance to the organizational hypertrophy and opaque administrative mechanisms of the managed care era. However, consumer-driven health care suffers from its own shortcomings. Blunt cost-sharing provisions, unadjusted for the patient's income or health status, will penalize the poor and the sick while allowing their wealthier and healthier compatriots to retain higher balances in their HSAs. Nonselective network designs, the dismantling of utilization management, and a reversion to fee-for-service payment will encourage spending for high-cost services that fall above the insurance deductible. The emphasis on measurement, payment, and choice at the level of the individual practitioner rather than the provider organization will disvalue the information technology, managerial, and cultural infrastructure necessary to integrate care across comorbid conditions and codependent services.

After having tried every alternative, it is to be hoped that a market-oriented health care system will do the right thing and combine the best elements of the demand-side approach embodied in consumerism with the best elements of the supply-side approach embodied in managed competition. The combined approach could be termed *managed consumerism.*

A market-oriented approach must always put the consumer first before the provider as the locus of rights and responsibilities. But the full potential of a consumer-driven system will be realized only when insurers create meaningfully distinct networks and providers create meaningfully distinct organizations among which informed and cost-conscious consumers can choose. As suggested in Exhibit 2, different consumer-centric benefit designs and provider-centric network designs will be appropriate for different health services, depending on whether utilization is strongly consumer preference–sensitive, provider supply–sensitive, both, or neither. Health plans are experimenting with various forms and levels of cost sharing and provider payment across services according to the sensitivity of demand and supply to financial considerations. As sketched in Exhibit 3, different forms of organization may offer the best combination of cost, quality, and convenience for different services depending on their clinical and technological characteristics.

The health care landscape is blooming with minute clinics for low-acuity primary care, medical homes for chronic care management, centers of excellence for high-acuity surgical procedures, and focused factories for ambulatory surgery and oncology. Consumer choice needs to be combined with organizational management so that the pursuit of individual self-interest through market competition vicariously supports the social interest in an efficient, fair, and effective health care system.

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