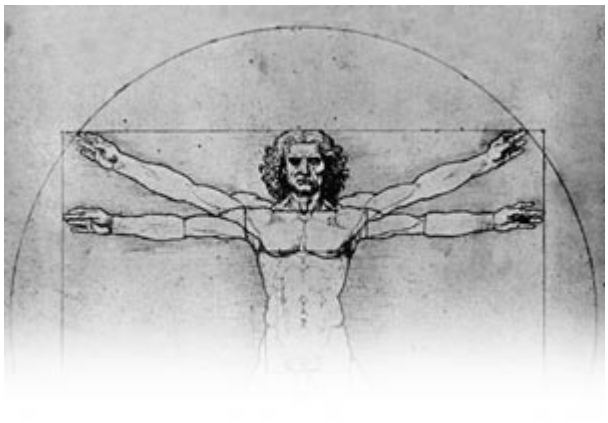
The National Consumer Driven Healthcare Summit

*The Leading Forum on the Implications of Consumer Choice and HSAs, HRAs and FSAs for Providers, Pharma, Plans and Employers*


# Exclusive Faculty Survey and White Papers on Improving Consumer Driven Care

Compiled by MCOL on behalf of the National Consumer Driven Healthcare Summit
September, 2007



## SECOND NATIONAL CONSUMER DRIVEN HEALTHCARE SUMMIT

*The Leading Forum on the Implications of Consumer Choice and HSAs, HRAs and FSAs for Banks, Providers, Pharma, Plans and Employers*

**September 26 - 28, 2007**
**Hyatt Regency on Capitol Hill**
**Washington, DC**

# The National Consumer Driven Healthcare Summit Faculty Survey

While many positive results and developments regarding consumer driven care have been announced by a wide variety of organizations, there is also material criticism directed at consumer driven care by various parties. With such a diversity of positions, opinions and data regarding Consumer Driven Care, it is instructive to seek the collective wisdom of the national experts on the subject, regarding their viewpoints.

In this exclusive survey of current and past National Consumer Driven Healthcare Faculty conducted by MCOL on behalf of the Summit, we searched for the pulse of the leading experts and stakeholders around the country, regarding what they feel are the important components, valid criticisms, and general areas for improvement regarding Consumer Driven Care.

The Faculty was asked to respond to three issues. Each was provided a list, in which they could check as many items as they agreed with, regarding:

1. Which items they felt were very important and positive components of consumerism;
2. Which general criticisms of consumer driven health plans they felt were at least somewhat valid;
3. What general areas they felt it is important for further improvements to be made throughout the industry.

It is important to note that the Faculty represents perspectives across the spectrum regarding Consumer Driven Care. Some of the faculty strongly advocate Consumer Driven Health Plan initiatives, others actively oppose them, and a number are in a more neutral role.

Significant consensus was found throughout the faculty regarding:

- Provider Price Transparency, Provider Quality Transparency, Wellness Incentives and Health Savings Accounts are important components of consumerism (93%, 90%, 70% and 66% respectively agreed with these items)
- Enhanced Consumer Health Information Tools; Increased Provider Transparency; Improved Consumer Communication Pieces and Tools; and Increased Availability of Wellness Incentive programs are all important areas for further improvement throughout the industry (95%, 95%, 71%, and 66% respectively agreed with these items)

A majority of the faculty (greater than 50% but less than 66%) also agreed with:

- The following items as being very important components of consumerism: Account Debit Cards, Convenient Care Clinics, Health Care Treatment Option Information Tools, Health Reimbursement Accounts (HRAs), and High Deductible Health Plans (HDHPs)
- Deferral of Care, and Not Meeting the Needs of the Chronically Ill as being at least somewhat valid criticisms of Consumer Driven Health Plans
- Simplified Consumer Explanation of Benefits and Other Plan Documents, and Further Modifications to Plan Design as being important areas for further improvement throughout the industry

Certainly the major takeaway from these results is that over 90% of the faculty cited the importance of provider transparency and consumer communication pieces and tools. Detailed results of the survey are provided in the following pages. In addition, seventeen faculty have contributed brief white papers with their perspectives on how Consumer Driven Care can be improved. These white papers are provided following the survey results.

*The National Consumer Driven Healthcare Summit Faculty Survey was conducted by MCOL in August 2007, with results compiled and published for Summit Attendees in September, 2007. Forty-one faculty responded to the survey.*

## The National Consumer Driven Healthcare Summit Faculty Survey Results

1. **Important Components**: Please check which of the following items, often associated with various aspects of consumerism, that you feel are very important and positive components of consumerism (you can check none, all, or as many as you like)

92.7% Provider Price Transparency

90.2% Provider Quality Transparency

70.7% Wellness Incentive Programs

65.9% Health Savings Accounts (HSAs)

56.1% Account Debit Cards

56.1% Convenient Care Clinics

56.1% Health Care Treatment Option Information Tools

51.2% Health Reimbursement Accounts (HRAs)

51.2% High Deductible Health Plans (HDHPs)

34.1% Flexible Spending Accounts (FSAs)

31.7% Defined Contribution Health Plans

26.8% Customized Health Plans

14.6% Other (please list item):

- Consumers being able to manage their own health data
- Unbiased information about quality and price
- e-Visits, Patient Health Records, information therapy deferral
- Price consistency, physician and other information much more readily available, openness to new forms of service
- Consumer ratings of providers against evidence-based criteria
- Employers fully supporting funding and education

n =41

## The National Consumer Driven Healthcare Summit Faculty Survey Results

2. **Valid Criticisms:** The following are often quoted general criticisms of consumer driven health plans offered by critics. Please check any general criticisms that you feel are at least somewhat valid (you can check none, all, or as many as you like):

53.7% *Deferral of Care:* A significant potential exists for Consumer Driven Health Plan enrollees to defer medically necessary care due to the high deductible requirement, their account balance or both

51.2% *Chronically Ill*: Consumer Driven Health Plans are poorly designed to meet the needs of the chronically ill

43.9% *Unqualified Consumers*: Consumer Driven Health Plans are asking consumers to be bear more responsibility for health treatment and health benefit decisions than they are prepared and qualified to make, given the inherent complexities

41.5% *Adverse Selection*: Consumer Driven Health Plans draw healthier, more affluent enrollees leaving sicker employees in other plans

39.0% *Lack of actionable data*: Not enough qualified data yet exists to warrant justification of significantly expanding consumer driven initiatives

34.1% *Unfunded Accounts*: A significant number of HDHP enrollees have not opened Accounts, or have negligible account balances

29.3% *Discriminates*: High deductible plans discriminate against classes of people who have relatively higher health care costs applied to high deductible requirements, such as women or infants

26.8% *Consumer Satisfaction*: Enrollees of Consumer Driven Health Plans are significantly less satisfied compared to enrollees of more traditional plans

14.6% *HDHP Premium Savings*: Health Plans are pocketing most of the savings from High Deductible Health Plans, and not passing on the appropriate level of savings in premium dollars

19.5% *Other*: (Please list item):

- Not enough information on price and treatment alternatives yet
- Tax benefit favors high bracket taxpayers; tax benefit should take form of refundable 15% tax credit
- Could result in higher premiums for those not in high deductible plans
- Transparency data weak
- Such plans tend to be regressive, not helping those in lower tax brackets
- Lack of freedom in plan design
- CDHP discriminate against women
- Consumers need info to make decisions; pricing before or at POC, quality comparison info

n =41

## The National Consumer Driven Healthcare Summit Faculty Survey Results

3. **General Areas for Improvement:** Please check any applicable general areas where you feel it is important for further improvements to be made throughout the industry:

| | |
|---|---|
| 95.1% | Enhanced consumer health information tools |
| 95.1% | Increased Provider Transparency |
| 70.7% | Improved consumer communication pieces and tools |
| 65.9% | Increased availability of wellness incentive programs |
| 63.4% | Simplified consumer explanation of benefits and other plan documents |
| 53.7% | Further modifications to plan design |
| 46.3% | Further state or federal legislative and regulatory changes |
| 39.0% | Improved Account Integration |
| 36.6% | Greater range of choices offered with consumer decision making |
| 36.6% | Higher level of employer account contributions |
| 36.6% | Increased availability of account debit cards |
| 31.7% | Incorporate more care management programs and techniques |
| 9.8% | The entire concept would need major re-tooling |
| 12.2% | Other (please list item) |

- Consumers need greater opportunity to obtain care from non-physician caregivers, who should be permitted to practice independently subject to greater quality control than MDs.
- Focus would more appropriately be placed on achieving system in which everyone has coverage
- Provider billing/carrier payment approaches
- Information prescriptions with every new diagnosis, test, medication or procedure.
- Reward consumers and providers, interactively

n =41

## Improving Consumer Driven Healthcare…

White Papers from contributing current and past National Consumer Driven Health Care Summit Faculty

# Consumer-Drive Healthcare Can Achieve a Win-Win-Win

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The key to consumer-driven healthcare's long-term success will be its ability to align the interests of healthcare's three key stakeholders – the consumer, the provider and the purchaser/payer, in a win-win-win proposition. We call this an alignment-of-interests™ or "AOI™" method and the process is called "triangulation™." We liken this concept to balancing a three-legged stool. If any one leg of the stool is shortchanged, then the stool will tip-over, and that solution is judged to be "fundamentally flawed."

The best example of a fundamentally flawed solution is in the case of HMOs. Purchaser/payers (i.e., the HMO) offered prepayments (capitation) to providers for patient care. It was well understood that when the HMO and provider rationed care to the patient, then the residual revenue could be pocketed by these two legs of the stool. Through much of the 1990s, healthcare inflation remained in check due in large part to HMOs. Eventually, the third leg caught on. After a number of famous lawsuits and the Patient's Bill of Rights, the HMO scheme was exposed for its fundamental flaw, and HMOs are no longer an effective way to control health care costs.

So how well does consumer-driven healthcare (CDHC) stack-up against the AOI test? Who wins and are there losers among our three key stakeholders? It is fairly obvious that the idea behind high-deductible CDHC is to shift costs from the purchaser/payer to the consumer. So the purchaser/payer wins and the consumer would seem to lose. However, the consumer can win, too, through a savings plan that is "theirs" to keep or at least to invest for a rainy day. This keeps the consumer engaged much like HMOs did by offering the consumer no or limited out-of-pocket costs. And much like HMOs, as long as the consumer remains in relatively good health, then CDHC will be a good deal for the consumer. However, it is when the consumer develops a chronic or severe condition that a loser can appear. In effect, the consumer's nest-egg can become depleted, leaving the consumer with little or no recourse. This is the big knock against high-deductible CDHC. Another concern is that CDHC stratifies the healthy and wealthy from the sick and poor. This process of creating winners and losers destroys the concept of insurance risk pooling. If unchecked, the CDHC stratification process will hasten the need for a governmental solution to cover the chronically and severely ill.

From the provider's perspective, there does not seem to be a win with CDHC. Providers are concerned that high deductible health plans will mean more collection costs and more bad debt. There is little doubt that the concept of provider transparency is appropriate, unless you're a provider who must invest to measure up.

So is there anything that CDHC can do to create a win-win-win or is it fundamentally flawed like capitated HMOs? There is little doubt that CDHC must find a way to resolve the issue of the poor and sick. We have heard of some creative ideas to scale the benefit design based on need. This could have the effect of restoring the risk pool so a government solution is not necessary. Beyond this, there is a method that CDHC could incorporate that has been proven to achieve an AOI through triangulation. Let's examine this method against the overall status of American healthcare.

The objective of any healthcare delivery system is straightforward - provide access to high quality and affordable health care to everyone. We have the most expensive health care on earth, and yet we can do no better than 41$^{st}$ in infant morality and 42$^{nd}$ in life expectancy. The number of uninsured has recently grown to 47 million. To make matters even worse, America has a growing shortage of doctors. The U.S. now ranks 43$^{rd}$ in the world in the number of physicians per capita. How can this be? How can we spend more on healthcare than any other nation on earth and yet have a growing number of uninsured and rank only 43$^{rd}$ in the number of doctors?

*Jeffrey Greene continued*

There are four underlying causes of the problems described above. These causes are as follows:

1. **Poor Quality of Care** - I can site important studies that indicate we receive inferior care in America. One such study[1] found we get recommended care from our doctors only about half the time and another study[2] says that mistakes in hospitals is the 4th leading cause of preventable death in America. Our health care system is simultaneously famous for providing the most advanced medicine on earth and for being inefficient and chaotic. How can CDHC fix the quality of care? Some suggest provider transparency. This may be effective with hospitals, pharmaceutical companies and other goods and services in ample supply. But how do you get doctors to improve quality when they are in short supply. It would seem that we need to make the doctor's work-life better and more attractive to increase the supply, not make it less attractive.

2. **Misaligned Incentives for Providers and Consumers –** With regards to misaligned incentives, let's start with the consumer. CDHC can have a positive effect on creating incentives for patients to be more accountable. Some, however, fear that the incentive to conserve money in a high-deductible plan will cause the consumer to delay needed health care. Some believe this can be fixed with incentives for prevention and treatment of known conditions. As far as providers are concerned, pay-for-performance or P4P, where providers are compensated for value and not volume, makes all the sense in the world - that is until we get bogged down in the detail. The running debate over how to measure and report provider performance, using the current thinking, will eventually doom the P4P movement in provider lawsuits. I can almost envision a Provider Bill of Rights. The metrics are wrong, the judging party is wrong, and the consumer is not engaged. CDHC could do something about this by adopting a provider incentive program that fixes the problems with P4P.

3. **Medical Illiteracy and Poor Doctor-Patient Communications –** This issue is often overlooked. However, a recent study[3] found that medical illiteracy is more harmful and expensive that we ever thought. Other studies[4,5,6] have shown how poor doctor-patient communications contribute to medical illiteracy. CDHC could address this through information therapy and incentives.

4. **Poor Health Habits that are Causing Epidemics in Preventable Diseases –** Americans eat too much and don't get enough exercise. This is the single biggest contributing factor to poor health and hyper-healthcare inflation. Interactive doctor-patient rewards are a key to behavior modification.

So, is there a solution CDHC could incorporate that addresses all of these causes of the healthcare problems that plague us? The answer is yes! It is a web-based incentive system that aligns the interests of the consumer, provider, and purchaser/payer. It involves evidence-based metrics that doctors embrace because they are anti-cookbook, and the doctors' judge is their own patients. It involves information therapy that financially rewards patients for demonstrating to their doctors that they understand and are compliant to recommended treatments. It involves creating financial incentives that, unlike pay-for-performance, are doctor-patient interactive such that both parties must declare adherence to a performance standard, and then confirm each other's declaration.

This incentive system rewards doctors for incorporating evidence-based treatments. It rewards patients for being accountable. It rewards doctors and patients for better communications and medical literacy. It encourages and empowers patients to be healthier. It has been proven to control costs and deliver a significant ROI to the purchaser/payer. In other words, it can help CDHC achieve a win-win-win by making healthcare better and more affordable while improving the consumer's level of health.

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1 The Quality of Health Care Delivered to Adults in the United States. McGlynn EA, Asch SM, Adams J, Keesey J, Hicks J, DeCristofaro A, Kerr EA. *New England Journal of Medicine*, Vol. 348, No. 26, June 26 2003, pp. 2635-2645 (Available as RAND Public Health, Quality of Care WR-174 <http://www.rand.org/cgi-bin/Abstracts/ordi/getabbydoc.pl?doc=WR-174>.)

2 HealthGrades Patient Safety in American Hospitals. August 2004.

3 Health Literacy and Mortality Among Elderly Persons. David W. Baker; Michael S. Wolf; Joseph Feinglass; Jason A. Thompson; Julie A. Gazmararian; Jenny Huang. *Archives of Internal Medicine.* 2007;167:1503-1509

4 The Effect of Physician Behavior on the Collection of Data. Beckman HB, Frankel RM. *Ann Internal Med.*; University of Rochester, 1984, 1999.

5 Is Your Doctor Really Listening to You? Kaplan SH, University of California, Irving, National Center for Policy Analysis. *Daily Policy Digest*; 2004.

6 Effective Physician-Patient Communication and Health Outcomes: A Review. Stewart MA. Can Med Assoc J. 1995;152:1423–1433.

# How the Concept of Consumer-Driven Healthcare Can Help Fix America's Ailing Health System

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The notion of consumer-driven healthcare contains the seeds of solutions to many of the problems facing American healthcare, but to date it has mostly exacerbated the problems by not focusing on the important concepts to be learned from consumerism. If consumer-driven healthcare is to be part of the solution rather than part of the problem, its advocates must see themselves as leaders rather than technicians, and completely rethink how consumer principles should be applied.

Here are two quick suggestions:

**First, ban the term "consumer" from everything to do with healthcare.**

Healthcare is not a "market," and therefore the term "consumer" or the terms "buyer" and "seller" are not really appropriate. (There is a reason that healthcare has traditionally used terms such as "hospital," "patient" and "provider," rather than "store," "buyer" and "seller.") Among other things, markets have free entry and exit of buyers and sellers, transparent prices and product information, and relatively few legal and other controls. None of those things apply to healthcare. More important, the purpose of a market – to allocate scarce resources – is not appropriate to healthcare, which should not treat its services as scarce resources to be allocated to the highest bidder. Thus, the term "consumer-driven" healthcare should be changed to "patient-driven" healthcare, and the terms "consumer" and "customer," as applied to healthcare, should be eliminated from the vernacular.

**Second, focus on the core concepts of consumerism, rather than peripheral dimensions.**

In general, the strategy for advocates of consumer-driven healthcare should be to create the best of both worlds – the benefits of consumerism and "the market," but without the downside. To date, almost the opposite has happened – many of the downsides of consumerism and market forces have infiltrated the healthcare market, without the key benefits. Specifically, the most important idea that healthcare should borrow from consumerism and free markets is transparency. That includes transparency in prices, transparency in products and services being provided, and transparency about quality and other dimensions of providers. All the talk about consumer-driven healthcare and healthcare "markets" is nothing but hypocrisy unless or until open information is provided to patients.

Another core concept of consumerism is fairness. Again, consumer-driven healthcare has done little or nothing to address that issue. Healthcare spending accounts and similar concepts are highly regressive, with the lion's share of the benefit going to those people in higher tax brackets. The extraordinary disparity in pricing between those who are part of negotiated health plans and those who pay for medical services out-of-pocket is another example of unfairness that no one has addressed.

A third principle of consumerism that is lagging far behind in healthcare is *advocacy*. The media occasionally have taken up the challenge of serving as advocates for patients, but the system itself needs far more in the way of built-in checks and balances. Hospitals, health insurers and other providers would do well to help the problem by establishing more ombudsmen, review boards and appeal panels that would create both a sense of fairness and a sense of advocacy for patients. The establishment of more monitors and advocates independent of providers is also needed.

*James Hutton, continued*

As a final example, a fourth core principle of consumerism that has not been addressed sufficiently is safety. For instance, conflicts of interest and an excessive attention to profits have caused drug companies, university research laboratories and regulatory agencies to play fast-and-loose with public health. Consumer-driven healthcare has an important role to play in reestablishing better safeguards.

**Conclusion**

The promise of consumer-driven healthcare remains substantial, but if not better defined and conceived, it has the potential to create the worst of both worlds (all the ills of consumerism without the benefits) instead of the best of both worlds. Advocates should take two important first steps by (1) changing the term to “patient-driven healthcare” and (2) focusing on the core tenets of consumerism, such as transparency, fairness, advocacy and safety.

# Information Therapy

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Health care is in crisis:

- A Cost Crisis—impacting global competitiveness, and putting care out of reach for the middle class.
- A Quality Crisis—in which people don't get the care they need nearly 55% of the time.
- A Workforce Crisis—denying people access to care, and overwhelming clinicians.

The resolution of these crises requires a transformation in the role of the average patient—the only health care resource with enough potential to make a real difference. The introduction of consumer-directed health plans has begun to set economic incentives to support the transformation. Yet, something more is essential to the solution. By engaging and empowering people with the information, tools, and training needed to self-manage their care, the cost, quality, and workforce issues of today can all be eliminated.

The transformation can come quickly and at little cost to the system through the broad-scale use of "information therapy" and the implementation of three simple rules.

Information therapy (Ix) is the prescription of information to help a person make a better health decision or a positive health behavior change. Health care systems must begin to provide Ix prescriptions to every patient at every moment in care. The information and tools provided will allow them, working with their providers, to implement the three simple rules needed to save our health care system:

1. **Help people do as much for themselves as they can.**
2. **Help people ask for the health care they need.**
3. **Help people say "no" to the care they don't need.**

Healthwise is a not-for-profit organization with a mission to help people make better health decisions through the implementation of these three rules. Working with its hospital, clinic, health plan, disease management, and Web portal partners, Healthwise has developed three layers of an Ix Solution now available for implementation in both payer and provider markets

The Ix Solution can help save health care from crisis—it may be the only thing that can.

You can find more information on the Ix Solution at www.healthwise.org. And you can learn more about information therapy from the Center for Information Therapy at www.ixcenter.org.

# Seeing is Believing: Consumers Need to See What They're Getting

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***"Good judgment comes from experience, and a lot of that comes from bad judgment."***
***-- Will Rogers***

Consumers have little to no experience in purchasing healthcare. Their experience in paying for office visits or drugs or hospital services has been limited to co-pays and deductibles that frequently mask the full price.

So, in a consumer-driven health market, it's illogical to assume that they'll make good decisions. Even assuming they have the right information, they haven't had experience in making decisions. They'll probably make a lot of wrong decisions before they start making the right ones. That's why it's up to health industry leaders to ensure that they're delivering the most relevant information, information that goes beyond mere transparency. Transparency is vital to making good judgments, but even then some consumers will make bad judgments. They won't ask the right questions, they'll rely on faulty information, they won't understand the nuances of certain data, they'll ask the wrong source. They'll need a little help, and the industry needs to work together to ensure that the right information gets to each patient.

Infusing a flood of publicly available information on today’s $2-trillion health marketplace will cause disruption and unintended consequences. To prepare, here are some recommendations from our report, "Seeing is Believing: A sustainable framework for achieving transparency in the health industries."

A transparent health community should have the following goals as a framework:

- Information about cost and quality that is trusted by stakeholders. This should include price information that covers the total cost of an episode of care or a given condition; quality measures developed with physicians and hospitals, and patient compliance information to monitor outcomes. Focus on information that can be shared without compromising competitive advantage of stakeholders

- Incentives for patients, providers and payers that improve the efficiency and effectiveness of care. Misaligned incentives create frustration for all stakeholders. Incentives need to be adopted that drive patient behaviors toward health.

- Connectivity to disseminate information through interoperable health information systems. The industry needs to cooperate on efforts to create interoperarable networks for electronic medical records and clinical systems

# A Critical Component to Solving the Affordability Crisis

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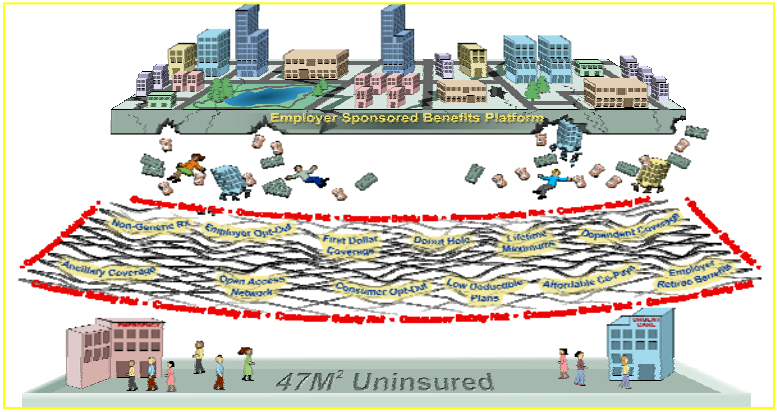
## *Employer Affordability and Coverage Crisis*

In recent years, U.S. employers have been casting their health benefit ballots liberally – their actions include reducing their contribution share, streamlining benefits, limiting eligibility or exiting the market entirely. While the progression has been gradual, the result has been a significant erosion of employer sponsorship creating visible cracks in the foundation of the private health benefit market. Over the past five years, consumers have shouldered $72B more in healthcare costs and an additional 6M employees have fallen into the ranks of the uninsured. History speaks loudly on this pivotal issue: the private or employer-sponsored health benefits market is not sustainable without major progress on affordability.

## Private Healthcare Marketplace Foundation is Under Stress




## *Is Consumer-Driven Healthcare the Solution?*

Employer cost shifting and tax sheltered saving accounts have been instrumental in shaping the early development of the consumer health benefit market. Many employers favor increased consumer financial responsibility and the resulting trend mitigation that comes with the cost shift. Consumer-driven health (CDH) leaders, however, see the model as a central part of the solution and believe it will drive the fundamental changes required to improve the healthcare system. The promise of the consumer-driven market is the achievement of progressive improvements in the cost and quality of care through consumer engagement, stemming trend and enabling affordable coverage. While the promise is high, progress is slow.

While employers have been effective in creating a more financially accountable consumer through cost shifting and providing tax-sheltered spending vehicles with accompanying cost and account management tools, attitude and behavior change are needed to drive fundamental improvements in treatment compliance, complex care coordination, utilization and ultimately trend. In this respect, payers have not revamped their service models sufficiently to raise consumer awareness and engagement to the level required for notable improvement in health status or to shift clinical and treatment decision-making. Nor have payers been able to parlay the collective voice of the consumer into increased provider competition (fee-for-value) or systemic market changes (“Four Cornerstones”).

*Tom Main, continued*

| Promise of the Retail Market Place | | |
|---|---|---|
| Market Stage | Retail Market Development | Market Progress |
| *Stage IV: Transforming* | *Collective consumer voice driving market reform* | |
| *Stage III: Maturing* | *Increased health management engagement resulting in behavior changes and improved outcomes* | |
| *Stage II: Developing* | *Informed and improved healthcare decision making* | |
| *Stage I: Emerging* | *Financial engagement* | |

## *Early Consumer-Driven Healthcare Market Breakthroughs are Compelling*

Health plans have made significant investments in consumer-driven health models to enable improved consumer decision-making and health management. CDH pioneers have driven meaningful breakthroughs—where innovative solutions have resulted in positive measurable outcomes:

- Humana Smart Suite's 4.2% trend guarantee
- Definity members' consistent use of preventative care
- Notable medical cost declines among CIGNA's CDH enrollees
- Aetna's groundbreaking transparency initiative

Despite the progress, overall market adoption of consumer-driven alternatives has been slow and solutions have been primarily focused on increased financial accountability and informed decision making (Market Stages I and II) rather than health management engagement and behavior changes (Market Stages III and IV). Consequently, industry medical trend remains high and employer sponsorship continues to erode.

## *Consumer-Driven Healthcare Alone is Not Sufficient to Solve the Employer Affordability Crisis*

Consumer-driven healthcare is in many ways a misnomer as consumers are not driving the change in healthcare but rather being thrust into a more financially accountable role with limited support. This shift in responsibility has been abrupt and follows a decade-long period where health benefits were part of the job and the employer was the health plan's primary customer. Consequently, it is not surprising there are significant barriers slowing consumer-driven market adoption and development.

The CDH model alone is not sufficient to effectively address the root cause problems driving medical trend or to solve the growing employer affordability crisis. Health plans must partner with consumers in the change process while leveraging their collective market clout to drive essential market changes that are well beyond the reach of the consumer.

## *Realizing the Promise*

Accelerating the market change process requires progress on market fundamentals like consumer engagement, employer commitment, provider alignment, industry standards, distribution capabilities, information integration and public/private sector collaboration models. Health plans are on the precipice of effecting durable market reform. The significant investments made over the past five-years have dramatically increased constituent awareness of the issues and effectively shifted the market from Stage I: Financial Engagement to Stage II: Informed and Improved Decision Making.

With the employer-funded private health benefits market at risk, employer sponsors are ready to reward market leaders for bringing Stage III: Increased Engagement and Stage IV: Collective Consumer Voice solutions to market. Tired of benefit buy-down products, the employer market is reaching it's tipping point and is looking for sustainable affordability solutions at a point in time when investment and market monetization cycles are beginning to align.

# Driving Consumerism: Buckets on the Titanic and Doc Cops

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Problems with the U.S. healthcare system are almost too expansive for most mere mortals to comprehend. Culpability is often associated with constituents that have evolved reacting to a strangely unique set of economic forces. Without indulging in a lesson on the history of U.S. healthcare, let's explore the macro symptom of the problem: runaway, escalating costs.

Laws of economics would suggest that costs rise because of an increase in demand, or in healthcare terms, an increase in "utilization". There are two main reasons that utilization is rising: 1) the National Institute of Health has documented that, in the U.S., poor lifestyle choices (e.g. smoking, improper diet, lack of exercise) result in approximately 50% of the utilization in our healthcare system and 2) a litigious disease has taken over the healthcare industry resulting in a misallocation of resources. Providers are subject to performing excessive testing when diagnosing a condition to avoid potential litigation associated with a misdiagnosis. Because of the insatiable thirst for healthcare in this country, previously fed by open checkbooks of U.S. employers and the Federal Government, the medical technology industry has created more advanced, often expensive testing technology (e.g. the MRI). This confluence of conflicting forces, the positives associated with available medical technology combined with an unchecked escalation in the amount of lottery-type malpractice settlements (forcing increases in the cost of malpractice insurance), are together, driving over-utilization of the healthcare system as a reaction to mitigate provider liability.

### *Consumer Behavior Change: Organic vs. Carrots and Sticks*

In order to address the first problem, consumer behavior change is necessary. Nike's campaign of "Just Do It" epitomized a health revolution in the Western world during the 1980's. A convergence of behavioral influences caused American consumers to become more health conscious. Contemporary icons included models and men with six-pack abs; GQ and Glamour magazines hit the shelves with images of these thin, beautiful people. Jogging and gym popularity exploded. Sports like racquetball were featured in hip movies. Styles changed to reveal body shapes with less coverage. This was an organic revolution, spawned by pop culture, and fed by reinforcement in advertising of consumer brands like Nike. The net/net wasn't a bad thing; Americans discovered we felt and looked better by being active. Many of us have carried good habits forward from the 80's. The current popularity of Yoga and Whole Foods supermarkets validates that there is a trend toward holistic health. Furthermore, as smokers have become the minority, smoking is banned in commercial establishments in most major cities and public buildings.

However, several of the largest growing demographics in this country cannot afford to shop at gourmet stores nor have the disposable income to join a gym. The older baby boomers arguably missed the era of "let's get physical". Much of the U.S. population is ignorant of healthy eating behaviors and let's face it, when you can buy a filling (albeit packed with empty calories) meal of fast food for under $4.00, junk food is cheaper than eating healthy. A large percentage of Americans are obese and life-style induced Type 2 diabetes is an epidemic. Stress and anxiety can be the sleeper root causes of any individual's propensity to have bad habits. If Americans want an excuse to eat poorly, drink too much alcohol or smoke, they don't have to reach far. There is a curious bifurcation of extremes in the population, not necessarily associated with socioeconomics. Healthy behaviors do not dominate any demographic and thin doesn't always equal healthy!

The enormous cost of absenteeism and presenteeism, compounded by healthcare costs of a less-than-healthy employee population (not to mention the cost that the uninsured is taxing our healthcare), is forcing employers to get involved and drive healthy behaviors with carrots and sticks.

*Teresa O'Keefe continued*

Examples include: dollars added to retirement accounts or a "smoking tax" added to premiums as a disincentive to smoke. It will take many years and zigs and zags of employer sponsored healthcare to address consumer behavior to make a profound effect on healthcare costs. Chances are that carrots and sticks will create the awareness necessary to create a healthier workforce, but wholesale consumer behavior change is not likely in the near future.

Vehicles such as Health Savings Accounts (HSAs) appeal to people that already save. Most of the population in the U.S. doesn't save and a huge sector of the population is unbanked. If people aren't saving now for the future, why would they start saving for healthcare? (As a side note, the tax advantaged *spending* features of HSAs should be emphasized). These initiatives are buckets bailing water off the Titanic for employers. However, a bucket for every person subject to employer-sponsored healthcare is about 150,000,000 buckets! The impact on national healthcare consumerism will be profound as millions of micro-economic events occur where employees start behaving like healthcare consumers and demanding more choices, convenience and control.

Regardless, most employers and other plan sponsors should move to account-based health plans that give consumers a wallet of limited funds to spend on healthcare, designed with incentives to save versus spend. If thoughtfully deployed, early results suggest these plans are a proven catalyst to change consumer behavior, even if slightly, and help to control costs. However, for the first time, consumer behavior change is being addressed by an industry that has taken a paternalistic approach to providing benefits and care, where marketing was focused on plan sponsors, the source of the money, not the consumer of goods and services.

We are now asking consumers to take responsibility for themselves and their family's healthcare. This doesn't present a "communications challenge", as commonly touted in the industry; it's a larger, *consumer marketing* challenge! We are selling employees something that they aren't sure they want. It's amazing that the largest industry in the country isn't employing better consumer marketing or at least understanding strategies and tactics of consumer marketing like: brand affinity, organic marketing and cross brand advertising. Furthermore, employers bear the largest burden of change management. It is anathema to most employers to engage consumer-marketing techniques to communicate with their employee population. The successful companies in the space will figure out how to promulgate effective consumer marketing through employer sponsored healthcare.

***Malpractice + Technology = $Gazillions Pumped out of Efficient Healthcare***

When you pose the question of "what will fix healthcare" to elder doctors that have witnessed the changes in healthcare over the last 40 years, there is a resounding consistency in where they suggest the root problems lie in healthcare: malpractice. Because of the high levels of malpractice lawsuits and awards (e.g. the potential of "lottery" type settlements), millions of dollars are misallocated in the industry to lawyers, plaintiffs, and the medical industry's providers of testing and "CYA" procedures. Dollars that should go into providing preventative and better care to more people are being spent on malpractice insurance, attorney's fees, and exorbitant tests and procedures that aren't necessary. Healthcare utilization will continue to be extraordinarily high until malpractice exposure can be eased and more dollars are devoted to research that can efficiently diagnose and treat the most common conditions that cause the highest amount of utilization to diagnose.

Nevertheless, practitioners that lament about malpractice should understand that the issue is even deeper. Malpractice came about as a check and balance to a system that manages itself in the quality of delivered care; effectually, it wasn't managing itself. In order for malpractice to be mitigated, tort reform and damage caps will have to be asserted, but more importantly, the medical community is going to have to answer to compliance in a more structured way. The AMA and other private medical boards may be handicapped in their current charters to act as the policing organization, although they could be responsible to drive the design of a compliance format. The format should require standard levels of performance expectations, specific to each medical discipline, to drive overall transparency.

*Teresa O'Keefe continued*

Medicine has developed an opaque culture with a "don't ask, don't tell" policy. The medical community has inherent *disincentives* to police itself. That doesn't mean they do not want policing, they just can't do it to themselves. There is room for a "Craigslist" for doctors – possibly sponsored by a consortium of health insurers, public entities, and large employers that would promote advocacy and reporting. It must be third party and non-profit. At first, it might be voluntary, but large employers' could provide incentive for doctors to join. After a while, if doctors are not part of the organization, which requires regular monitoring and reporting of basic discipline measurements, then they are subject to the scrutiny of not being part of an organization having a consumer's seal of approval. The organization could also drive the facilitation necessary for cost transparency.

Websites exist today that consolidate information about providers for consumers, but do not necessarily allow input, or the information is just a referral. Some charge about eight dollars for a fancy report and the ability to input information into the system – not something that most Americans will spend money on. Why should a consumer pay to provide information? In most cases, the data is generally retrievable from the state's board of physicians public website. For-profit enterprises normally do not want to be in the business of rating doctors – for fear of lawsuits from providers. Neither the pay-by-the-drink nor most public websites offer advocacy or the ability to file a "concern". A consumer can only file an open-ended complaint to the respective state's board of physicians. The consumer may not want to file an egregious complaint, but just want others to know that she's had issues with a doctor, and in turn, would like to know if others have as well.

Heavy regulation in the healthcare industry is the last thing it needs. However, more transparency is only going to happen through forced regulation or a not-for-profit, third party mechanism. Consumers need to work with a regulatory board to acquire information and supply feedback to the medical community. Today, their only recourse is to sue.

Hospitals, clinics and practices can begin to change the tide with a serious patient advocacy initiative, not rolled into their mandatory Medicare/Medicaid quality control function, but truly a consumer advocacy service that is advertised and communicated to every patient who is treated. Hospitals should have a Chief Advocacy Officer. An entrepreneurial opportunity exists to create advocacy programs in provider's offices and clinics that reports directly to the managing partners. The charter of the service is to receive feedback directly from consumers to help mitigate problems with delivery of care or administrative services. In effect, the provider establishment will become consumer-focused and self-regulating. An investment in advocacy provides potential malpractice avoidance by establishing a mechanism for consumers to have a voice and channel for providers to receive feedback to address issues before they become lawsuits. Malpractice insurance premium rates should take establishment of such a service into consideration or become more active in demanding the delivery of consumer advocacy.

# Setting Proper Expectations

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CDH starts with setting proper expectations. All parties involved must realize and agree on realistic goals and the timeframe for achievement. We need to look at the whole package not just one of the components. As programs become more complicated, clearly communicated consumer information plays a significant role in the success of the offering.

Employee Satisfaction with Benefit Plans for small and mid sized companies has dropped over the last five years largely due to changes driven by price increases. Cost shifting strategies leads the list of changes to include higher co-pays for physician visits and prescription drugs, larger deductibles, higher out of pocket maximums and greater cost sharing amounts for employees. Imagine how CDHPs would have been perceived absent the large increases in overall program costs.

CDHP design if correctly structured looks attractive to low plan users and high plan users. Only the mid level plan uses (they hit the annual deductible each year, but not the annual maximum out of pocket amount) are torn between a multiple plan approach as to their guess of will this be a better claim year so select plan A or will this be a more costly claim year so select plan B. An example of a well designed CDHP would be to look at the true cost of the CDHP plan, the amount set for the employee cost share, embedded or not embedded deductibles, maximum annual out of pockets, all compared to the traditional PPO offering. Then you take the majority of the savings on CDHP to fund the bridge or gap created by a larger deductible.

Responsibility for running a sound healthcare plan rest with all parties involved. The member should recognize that every uses of the system from prescription drugs to surgeries are spending real dollars that impact the member, the employer (if a member of a group plan), to the insurance carrier.

**Plan Members** should at least have an annual medical, dental and vision exam. The results of these exams should move the member to take action to stabilize or improve their health. Most people want to be covered under a PPO plan design giving freedom of choice to the member on how they select medical providers. We lost a key positive connection between the PCP and the member over the possible hassle of a referral limiting our option of specialist care. Every member should have a PCP tracking all medical care and consulting the member on options available to maintain and improve health. Even with the tools available today for transparency of cost and quality many plan members do not want to negotiate with the medical community. We still trust the our primary care physicians for much needed advise in troubled times. Some fundamentals have not changed for people to live a healthy life. It starts with an understanding of your health today. Participating in the annual testing should be mandated requirement of plan. Individual results of testing should never be used as a requirement. Physical activity in everyday lifestyle is a must to even think you are on track to being health. Nutrition practices including portion control, caloric intake, well rounded and low fat diet. Protecting the amount of quality sleep each night and don't smoke set the basics.

**Employers** should take responsibility for educating employees on the plan, tools that are available, incentives for staying healthy or improving health. Employers should allow for the creation of an employer sponsored Wellness Team to drive member participation. Savings created by the plan should be invested in the resources available to members meet these goals. Senior level support and participation will greatly enhance the success of the program.

*Ken Olson, continued*

**Primary Care Physicians** should be given incentives by contract for improving the health of the population they represent. A realistic goal of turning the old style of reactive medical treatment to more of a proactive and preventative model, taking the best out of managed care and adding consumerism if you will. With specialists and hospitals contracted on a pay for performance standard. Adopting electronic medical records is a must to stop waist and overuse of testing.

**Health Plans** should state reasonable profit expectations up front and invest overages in keeping rates affordable. It is only fair if the members and medical community are in the game of improving health to lower claims then the premium savings should be shared by all parties. Most CDHPs do not mention the positive effects of a behavior health component of plan design. The area of stress management and work family balance is not to be overlooked.

**Pharmacy Benefit Managers** need to help with Explanation of Benefits statements with every fill. Use program such as generic outreach to members using more expensive drugs. Bring back the over the counter options like Claritin and Prilosec as covered under the plan. It should be good news when a maintenance medication goes to over the counter. Let's make this a win for all parties.

**Broker / Consultants** are needed much more as an extension of HR then the people who know how to find an insurance company that has the best rate for the next twelve months. With employee education at the front of key success factors, here is an opportunity to have year round contact with members. Judge a broker / consultant on the ability to raise employee satisfaction with the program through education and tools provided.

**Plan Administrators** for medical claims, prescription drugs, HSA or HRA and FSA need to connect and allow for a financial statement to members that is easy to understand. Recently the move from paper claims for FSA to debit cards only to have new legislation take us back to submitting paper claims / receipts did not help. Let's make it easy to use the cash flow advantages of the debit cards and take the paper out of the system.

Long term rate stabilization or the beating of medical trend increases will be the result of a wiser population of members all working to uses the system less and making better choices when needed. As a healthy workforce, the benefits are impressive with less absenteeism, presenteeism, greater productivity and fewer accidents.

# Health Care IT and Financing's Next Frontier: The Potential of Medical Banking

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http://www.csom.umn.edu/Page2075.aspx?type=faculty&eid=122504855

I'm very excited about the prospects of medical banking. What intrigues me most is the integration of medical banking and person health records (PHR). There are three elements of vision of medical banking:

- Personal health records (PHR) are a portable resource that patients and their families can use for the long term.
- Patients will use PHR technology as a critical resource for health improvement, prevention, and long term medical care affordability.
- PHR will give patients emergency access to critical information and allow the record to be customized to clearly define their preferences for treatment. For example, pregnant mothers can clearly identify their delivery preference. A delivering OB/GYN still can counter the patient's preference for the safety of the mother, but there would be no ambiguity about the mother's wishes. Likewise, patients who want their organs donated in the case of mortal injury could make their preferences known.

The technology platform that appears to be emerging for medical banking is the integrated health card solutions. Several insurers have been experimenting with this technology. Of the early adopters Exante Bank of United Health Groups appears to have made significant progress in developing a product as well as a client base for a early for of this platform know as an integrate health care (IHC) technology.

Several innovations from the IHC technology are noteworthy. First, a PHR built upon a Medical Banking Integrated Health Card (IHC) technology platform facilitates payment and benefit transactions more efficiently. Specifically, it simplifies the process for patients and providing health care professionals. Second, the card will support access to essential health records that support care interventions. From a consumer perspective, this information transcends benefit plan boundaries and traditional geographic limits, enabling people to have their information and financial resources follow them across products or across the country. Third, the technology will let the average medical provider know about a patient's care from existing technology. Fourth, an online summary of their patients' medical histories can be built from the point of care. For example, a swipe of the card will give a physician access to the Personal Health Record that uses claims data and other data elements to automatically compile a comprehensive summary of critical information including: medical conditions, medication history, significant medical interventions and laboratory results. In addition, the Personal Health Record can be augmented by patients who choose to provide details such as allergies, immunizations and family history.

How might this iPHR technology operate in the ideal world? Consider Anna, a consumer with a diabetes who has just moved to a new city.

On January 1, 2008, she begins health coverage in a new health plan with iPHR technology. Prior to her start date, she receives a health benefit card with a magnetic strip from her employer. The iPHR web site provides a list of endocrinologists accepting patients in her area and quality scores for the providers as well as which ones are iPHR enabled. She selects an endocrinologist from the list and schedules an appointment for an initial consultation.

Prior to the visit, the Anna logs onto a secure iPHR web site from the health plan to verify her eligibility and adds limited personal health data such as emergency contacts and a 'do not resuscitate' order. Anna also requests her previous pharmacy history from a different health plan to be added to the iPHR.

*Stephen T. Parente continued*

When she visits the endocrinologist, the physician's assistant swipes the health card using a USB swipe card machine connected to the Internet. He swipe opens an iPHR page and requests the patient to authenticate her access with a password. She provides the required authentication, followed by approval for the physician to access the iPHR. The physician sees on the iPHR web site that the patient has already authorized the provider to review her past history. The physician reviews all prior drug history and proceeds to conduct an initial evaluation with some sense of patient compliance with medications for a chronic illness as well as prior dosing.

During the visit, the physician orders blood work for Glycolsolated Hemoglobin, blood sugar, and creatitine. Height, weight and blood pressure also are recorded on paper records. At the end of the visit, the physician's assistant bills for an initial evaluation on the iPHR web site. This links to the health plan's transaction engine that requests standard claims processing information (e.g., diagnosis and procedure codes) as well as the patient's height, weight and blood pressure. Since this a standard part of an initial evaluation (signed by the initial evaluation CPT code submitted) the web site knows to make the request. Since the patient's eligibility information is already known from the initial card swipe and the provider is known to the health plan by being iPHR enabled, the allowed amount for the initial consultation is transferred directly to the physician's practice business account. Additional cost-sharing is deducted from the checking account or credit card line the patient already has entered in her iPHR preferences. One day later, the patient receives an e-mail that the lab work has been completed and she can log onto the iPHR to see and comment on the results. The physician also receives the e-mail and is invited to comment on the lab results.

Anna sees the endocrinologist four more times during the year and keeps recording stable or improving lab values. At the end of year, the health plan invites her to comment on quality of care she has received since her HbA1c scores improved. If she comments, she will receive either a reduction in her co-insurance rate or a credit to her health savings/reimbursement account if she is enrolled in a consumer directed health plan.

Anna decides to shop for a new health plan using her iPHR data with clinical information, preferences and comments, and lab values. She finds she can get a 15% dscount from another plan because of her healthy habits as a diabetic patient. She decides to take the new plan and keeps her iPHR. The only changes are the designation of her health plan and eligibility criteria as well as the plan's provider panel, which are then pre-loaded into her iPHR web site.

Is claims data the right architecture? I believe it is. The date/time stamp is the most important feature of a transaction based system because it provides a data ordering construct for the PHR. The best medical records systems use time as the central marker for disease progression and health improvement. If the transaction based system had more clinically relevant and health outcomes data, then it would in fact be a substitute for a CPOE system and it would become a full fledged electronic medical record. Finally, if this record were coupled with the capability for the patient to augment and add information to the record, perhaps even on a transaction specific basis (e.g. a lab test, prescription order, or physician visit), the result would be a very powerful 'integrated' PHR (iPHR) technology.

Can this really work? Yes, given the right conditions. The biggest weakness of a health record built from insurance transaction data is that the data provided for billing and payment purposes are not complete from a diagnostic perspective. Insurance transactions provide little to no information on health outcomes and could be biased due to financial incentives inherent in payment rules from public and private insurers. However, these shortcomings are the faults of limited data, not the transaction-based data structure. For example, the Institute of Medicine's advocacy in 2001 of wide-spread adoption of computerized physician order entry systems (CPOE) indicates support for a more clinically relevant transaction (or order) based technology platform.

*Stephen T. Parente continued*

A perfect story of enablement may be brewing. States are eager to try ideas and this may an evolutionary innovation that could be important to show state-sponsored health reform to deflect a national initiative. A second favorable factor is bands willingness to engage in this market.

There are plenty of spoilers as well. Privacy comes to mind. Someone could state that 'No one should have my information other than me and I will not share it with anyone for any transaction'. I've heard this enough to say back to them 'Then live completely by a cash only health economy and make sure you encourage your parents and kids to do so as well. By the way, those who qualify for Medicare and Medicaid should also 'go off the grid' as well if this were an equitable policy position.' Or to quote the Economist magazine title of 1999, 'The End of Privacy' has already visited us.

In summary, the prospects of medical banking are remarkably intriguing – if nothing else as a prototype to comment for some signal of where provider, consumers and insurers are willing to tread in the future. Medical banking could an alternative to interoperability. It may a very real Plan B that could be faster and cheaper to deploy. The significance of the Medical Banking PHR new technology is its development based upon a currently accepted form of information technology, insurance payment transaction processing. It also provides a platform that links data across all sites of care without a command and control integrated delivery system. In the end, consumers stand a better chance to benefit from development of this innovation than the status quo.

# Making Health Care Consumerism Work

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"Consumerism," according to Webster's Dictionary, is "the promotion of the consumer's interests." Consumers are best served when they have readily available and relevant product information, prices that are posted and transparent, the ability to understand the product's personal value to them, and when incentives are aligned between seller and purchaser. How close are we to this alignment in health care? Not very close at all.

For employers, according to a recent survey by Towers Perrin HR Services, the top three factors critical to their company's success are: employee who understand the impact of health care costs on the business; employees who understand the true cost of health care services they utilize; and employees who are effective health care consumers. Employees, on the other hand, feel that they are good consumers if they display a positive attitude and try to do what the doctor orders; think carefully about how they spend health care dollars; and pay the right price (the copay)!

To realize the benefits of consumerism in health care, this cavernous disconnect must be bridged. How then, to accomplish this daunting task?

**Incentive Alignment.** Appealing to consumer's pocketbooks alone is misguided. Health care continues to be viewed as an employee entitlement. But healthcare is an experience, not a commodity. Consumerism is an attitude, not a product. Employees make health care decisions based on perceived needs. Health care is viewed as "disease care," not as "well being maintenance and enhancement."

Benefits and incentives must drive changes in attitude. Employees with healthy lifestyles should not subsidize those without. Connecting the head and the wallet is paramount. Promoting healthy behavior in and out of the workplace is critical. One must understand each employee's motivation and design programs that appeal to the individual. Easy accessibility to health coaches and health information in the workplace has been proven to change unhealthy behavior.

Specifically, employers should take a number of steps. :First, they should design benefit plan structures to reward those who are currently leading healthy lifestyles. Second, they should require that employees understand their health risks by mandating a health risk assessment as a condition of employment. Third, employers should make healthcare services and wellness counseling available on-site. Fourth, they should demonstrate clearly the link between compensation/benefit costs and take home pay for each employee. Fifth, they should educate and involve family members. Finally, employers should eliminate barriers to healthy living – remove unhealthy vendors and vending machines, provide exercise facilities including showers, begin all employee meetings with health education, and share and compare individual health care cost information.

**Provider and Payer Selection.** Employees may spend their entire career within one employer family but employers change insurance providers/payers every three years. This greatly inhibits the longer term view of employee health. Providers, in general, are reimbursed and incentivised to provide "sick care." On-site prevention and wellness care should be provided free of charge or should be part of any consumer-directed plan purchased on the employee's behalf. All employers should immediately offer a consumer-directed option and should quickly move in the direction of consumer-directed benefit plans as the "only" choice.

*Charles Peck, MD continued*

Importantly, executive management should walk the walk and participate in wellness programs and consumer-directed options. Payers should be required to provide on-site consumerism education as part of their offering. Any payer selected as a vendor should be required to reimburse providers fairly for wellness and preventive care. Providers providing this care alternative should be recognized widely by the employer. Employer health care decisions should be removed from the HR function, where it has become a “price play” rather than a “value play.”

**Outcomes, not processes.** Employees who demonstrably improve their health status through objective measures should be celebrated. Their stories should be shared with colleagues. Employer savings should be gainshared with employees who made it happen! Providers should be recognized through additional referrals and community acknowledgement. Payers who participate should be rewarded with longer term commitments. Executive teams should be recognized and rewarded by their boards.

The bottom line is this. A healthy lifestyle is not a project – it is imperative that must become part of the corporate DNA. Companies utilizing balanced scorecards should include health outcomes and cost as an organizational metric.

Product consumerism is the fabric of the American economy. Today, healthcare consumerism is still a dream. Undifferentiation begets commoditization. Aligning knowledge, motivation, and incentives are vital components for a health care system in dire need of positive change. Health care consumerism, if done right, can improve healthy outcomes and drive down spiraling costs. Let’s get started.

# Baby Steps or Wholesale Change: The Case for Value Transparency

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Most sectors operate in a manner where consumer demand and competitive dynamics drive customer utilization. In fact, a free market can be defined as one "where the price of an item is arranged by the mutual non-coerced consent of sellers and buyers, with the supply and demand of that item not being regulated by a government."[7] And accordingly, the opposite of a free market is a controlled market, where the government sets price directly or via regulation. Traditionally, the United States economy has operated under consistent notions of a free market, although anti-trust restrictions have imposed controlled market restrictions where a free market could corrupt consumer influence and cause anti-competitive activity. Although government does not solely regulate the activity, the U.S. health care sector, is more of a controlled market where price is determined not by the consumer, rather the ultimate payor – whether the government or a third party insurer. In addition, health care is one of the only sectors where the consumer likely does not, or can not, know the price they will be charged for a service prior to accessing that service. As a result, consumerism in the health care context has not existed because the tensions of supply and demand do not exist when the ultimate consumer is not the payor, and has no responsibility for weighing in on the supply/demand factor influencing the calibration. As a result, it is necessary to begin to utilize a model of price and value transparency, in combination with benefit plan designs that shift this calculus to the ultimate consumer. These changes are already proposed by various constituencies to help empower consumers and shift the health care sector towards a more free market concept. Retail Clinics have been particularly apt at driving this innovation into the health care marketplace.

Retail clinics are a microcosm for price transparency and consumer choice. Picture this: an individual walks up to a provider, sees the cost of the service, knows what the patient responsibility is with and without insurance coverage and can make an informed decision about whether to access that provider or go to another provider. This is what exists with retail clinics. There is a menu of prices, potentially a negotiated amount with a third party payor, and the ability of an individual to know their responsibility in the event they pay for the service out of pocket because they are covered by a high deductible health plan or are uninsured. This type of model allows individuals to make informed decisions about how they spend their health care dollars. This is critical in what is becoming more of a consumer directed health care market. Consequently, price transparency can help the consumer make informed decisions and potentially drive costs down for identical services at higher priced providers.

Most transparency initiatives today focus on providing consumers access to specific pricing for common procedures and physician services. Both health plans and providers have begun providing this information to consumers. However, a factor which is necessary to address is that price transparency, whether through the retail clinic model or the larger health care market, cannot be the sole factor for consumer decision making, rather there needs to be an additional quality element. If cost is the sole factor, a consumer making a health care decision may operate differently than in other industries where their health care needs are not directly at stake. For instance, a consumer may tend to use cost as a proxy for quality, without additional quality information, thereby potentially driving up price. Alternatively, given information relating only to the cost of services, consumers may seek to minimize costs for a given service or procedure, while assuming that the service they are receiving is a commodity with no variation in quality or outcome, regardless which provider they choose.

[7]Dictionary of Finance and Investment Terms. Barrons, 1995 --- "market in which price is determined by the free, unregulated interchange of supply and demand. The opposite is a *controlled market*, where supply, demand, and price are artificially set, resulting in an *inefficient market*."

*Sarah Ratner and Sean Gregory Continued*

Even for the simplest, lowest severity services, significant variation exists in the marketplace relative to the quality of care delivered and overall outcome.

One way to mitigate this potential is to allow for quality indicators to be disclosed, thereby becoming a factor in consumer decision making. For example, in the retail clinic context, MinuteClinic is Joint Commission accredited which is a quality certification. For other providers it could be a measure for how accurately they comply with evidence-based protocols or incorporate new technology into their practice. There are various components being discussed for national quality indicators which are being driven by several groups, including the Department of Health and Human Services, health plans, and provider groups. What is needed to drive consumerism in the health care marketplace is value transparency, which is information regarding the quality of the provider delivering the service and the costs for the complete course of treatment. Only then, can consumers begin to engage in, and make informed decisions for themselves and loved ones. Through this, consumers may begin to seek the optimal clinical outcome, at an acceptable price.

If value transparency exists (which is still debatable), the next element which can effect the evolution of consumerism and the demand of appropriate health care services is benefit plan design. Health plans, whether private or federally-funded, have the ability to provide incentives for consumers to appropriately and efficiently use health care services. First, health plans should encourage appropriate health care utilization by designing tiered benefit plans that promote the use of providers based on an evaluation of the quality and price for the service required. For example, a health plan could incorporate a zero co-payment for accessing a retail clinic for a strep test, and a slightly higher co-payment for going to a provider for a more complicated service, such as a diagnostic appointment for high blood pressure. Second, health plans need to develop readable health plan documents. Trying to figure out plan design and benefits is entirely too complicated and even with an appropriate plan design most consumers do not truly know how to use the health care benefits to which they have access. For consumers to access and utilize the incentives and options provided in such a benefit plan, the benefit plan must be easy to understand and use. As a seasoned health care attorney, I can barely understand my plan document and I cannot comprehend how a busy family juggling every day demands has time to read and understand plan design and then, when needed, triage the various plan components, and ultimately make an appropriate decision to access care. Until plans become more “user-friendly”, the promise of consumer directed health care will not materialize, even with the availability of quality and price transparency.

Ultimately, value transparency, in combination with the right benefit plan design, allows individuals to become empowered, requiring providers to compete on the basis of quality and price to provide services. The retail clinic concept is a model where individuals go to a health care provider and know the cost before accessing the service, as well as have the ability to compare the cost against other similar providers. However, until competition can be equalized and access understood by the consumer, the consumer directed health care movement’s potential will not be realized. As with most other health care reforms, this movement will likely provide incremental shifts to the system that, when added up, will provide necessary reform to achieve a full scale change to a financially tapped system.

# Consumer-Driven Healthcare: Putting the Pieces Together

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Bring up the subject of employer-sponsored health insurance to any employee, and you're going to get a laundry list of questions. Today's healthcare and benefit market is full of confusing plans, procedures, and policies. While consumer-driven healthcare (CDH) is clearly reducing costs, it's also increasing the demand for consumer information, education, and decision support tools.

New CDH plans give consumers a wide range of plan options, furthering the confusion and often times leading them to go with the status quo. Rather than try to understand new high-deductible health plans (HDHPs) and pre-tax benefit accounts, such as Health Savings Accounts (HSAs) or Health Reimbursement Arrangements (HRAs), consumers end up with the same coverage as the year before, despite the financial advantages of CDH plans. Payers, providers, and financial institutions must work together in order to alleviate consumer confusion, improve overall attitudes toward healthcare, and create a seamless experience for consumers. Although this may seem like an unattainable goal in today's fragmented healthcare market, it may be closer than we think. The technology required to weave the data and financial information together already exists, and it has been in use in other industries for years.

The growth of CDH has not only led to the need to educate consumers, but also a new method of moving healthcare information and payments in similar ways to the retail industry. It is clear that elements of the same technology used to support our existing retail systems can be applied to healthcare. By implementing comparable technology and facilitating connections between other data and payment systems of the healthcare industry, we can create a better and more efficient experience for patients, providers, and payers.

We'll be able to give consumers education, tools, and information to make choices that will enable them to manage their health and wealth. By leveraging existing technology, we can give them the tools to use their health plan wisely, to manage their personal health and wellness. Financial tools – including debit cards and sophisticated on-line calculators that factor in actuarial data on disease state, age, and other variables – will assist in planning for long-term healthcare savings. Better educated consumers armed with tools for decision making will ultimately lower costs and administrative burdens within our healthcare system and enable more resources to be devoted to patient care.

**Empowering Consumers**

The fast-evolving, consumer-driven healthcare environment is creating a need for consumers to apply the same kinds of buying criteria for health services and products that are applied in other areas of everyday life. The real demand is for transparency about price, quality, alternative treatment methods, and outcomes. Consumers need better access to pricing and quality information about healthcare services. Additionally, a consumer-retail environment in healthcare challenges consumers to make educated choices around saving for healthcare, so consumers must understand the benefits of today's expanding HSAs, and their employers must make it financially viable for them to enroll in these accounts.

For consumers to thrive in this environment, a convergence of healthcare and financial information needs to occur. It will be a key enabler for consumers and one of the biggest IT demands stemming from CDH. Even with commercially available technology (in the current retail and POS technologies), this is a difficult but achievable goal. But simply bringing the data together is not enough. The sheer volume of healthcare and related financial data would be overwhelming for the average consumer. The data must be simplified and condensed in order to create a purchasing tool that puts the free market forces in play in the healthcare industry so consumers can make better economic and health-related decisions.

*John Reynolds, continued*

Presently, quality information, such as a doctor's education or treatment history for a certain disease, is nearly impossible to find. As for pricing, even if you ask your doctor about the cost of a certain procedure, they often can't provide an answer because they literally don't have the information available to them. These are the primary obstacles facing the consumer-retail environment in healthcare today. By solving the quality and pricing information challenges present today, the future implications for consumers are positive. They acquire the opportunity to be as educated about a healthcare procedure or choosing a doctor as they are about buying a car or choosing a mutual fund.

**Streamlining the Claims Process**

Another practical reality is that payers largely control the claims adjudication process. With providers now taking on a more prominent role in bill collection in the consumer-retail healthcare environment, their ability to efficiently collect correlates directly to how quickly the payers adjudicate claims and determine a patient's financial responsibility. More rapid delivery of claim information is needed to adjudicate quicker and facilitate healthcare funds movement, and the onus is on the payers. Without efficient claims adjudication, providers don't know what to charge in a timely manner, and each passing day increases the amount of time and money spent on the collection process.

Unlike many merchants, healthcare providers can't repossess services when patients fail to pay. While real-time claims adjudication is the dream scenario over the long term, payers should strive for "right-time" adjudication in the short term. We don't have to go all the way to real-time to make a material difference or improvement in the claims adjudication process. The vast majority of healthcare claims represent easily priced single events, such as annual physicals or office visits for a cold or some other common ailment.

**Connecting to Traditional Financial Networks**

By putting existing technologies – initially developed to support other retail/merchant segments – into use for healthcare providers and payers, the financial services industry can do a lot to facilitate funds movement and improve efficiency.

Common card technology has reduced the cost of an average retail transaction to pennies by replacing checks and cash. Similar savings can be realized in healthcare with the same technology. Additionally, financial institutions can help accelerate the collection of receivables for healthcare providers, large and small, dealing with the increased collection activity inherent in the emerging CDH market. Helping merchants improve receivables collection is not a new challenge for financial institutions. Existing technologies like lockbox, check imaging, and specialized ACH formats can all be deployed to reduce mail and processing float for the benefit of payers and providers. Ensuring a seamless member experience is no more difficult than using common tools developed in other industries to facilitate the electronic movement of data and financial information between the three Ps: patients, payers, and providers.

**Pulling It All Together**

With so many pieces to this complicated puzzle, technology experts must rise to the challenge of bringing them all together and making them interoperable. A key first step is clear agreement on a set of standards that can be relied upon for data exchange. It may be years before the average consumer is able to fully leverage their CDH plan, but we must continue to push transparency, education, and other empowerment tools to get them actively involved in healthcare decisions to support healthy lifestyles and drive efficiency. Simultaneously, standardized technology and services must be deployed throughout our payer and provider markets to bring speed to the claims adjudication process and alleviate provider bad debt. Many technology vendors bring certain pieces to the table, but the ones that will succeed in today's healthcare and benefit market are those that are able to make all of the connections between the three P's of the consumer-driven healthcare puzzle.

# The Next Step – Integrated Wellness

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Consumer driven health care (CDHC) benefit programs have successfully engaged participants in understanding the true costs of health care. The programs have provided them with the tools and resources to understand, and impact, the cost of their care. Participants have made changes to their purchasing patterns such as switching to generic drugs or questioning the necessity of tests and procedures according to results from the October 25, 2006 Employee Benefits Research Group health confidence survey.

But purchasing health care services wisely is not enough. CDHC benefits must also reduce the frequency of health care services by directly engaging participants in health improvement activities.

One of the most powerful tools to improve health is incorporating wellness as a core component of the benefit program. Wellness benefits span a broad continuum from things such as on-line appraisals and newsletters to on-site health screenings. It's the health screenings that hold great promise for CDHC enrollees.

Health screenings begin with a comprehensive health assessment questionnaire, probing areas such as general health, family history, and health behaviors. This self reported information is combined with biometric information collected from the participant to give a complete view of their health status. The biometric data includes blood pressure, heart rate, body mass index, blood profile, height and weight.

After collecting the required information, an individualized profile is generated along with specific health improvement recommendations. The profile and recommendations are reviewed with the participant either in person or by phone. For those participants who have risk factors (which is generally more than half of the population being screened) they are enrolled into a targeted health management program.

The health management program provides the participant with ongoing support and education to better manage their specific health conditions. The participants are contacted throughout the year to determine progress on their health goals and to offer assistance. The participant elects how to interact with their health coach, either in writing, by phone or by email.

The program is designed to assist the individual by helping through the various states of change. For example, an individual who is significantly overweight is unlikely to begin exercising two hours a day starting immediately. Rather, the first goal is get them to contemplate changes in their diet and exercise. Preparation is the next step, followed by action. Once the participant has met their health goal they move to maintenance.

Each year the participant completes their screening and can track their progress over time. As their health improves, they will see financial benefits due to the structure of the consumer driven health care benefits. They will find improved health leads to a larger health savings account or health reimbursement arrangement balance because those funds are going unused. In addition, as employee health improves, the increase in health insurance premiums slows.

Consumer driven health care benefit programs simultaneously empower participants through knowledge, tools and support to make them accountable by attaching a financial consequence to their health and health care decisions. Wellness programs are a valuable tool to engage employees allowing them to get the most out of their CDHC benefits.

# How can CDH be improved: Education, Ease, Energy

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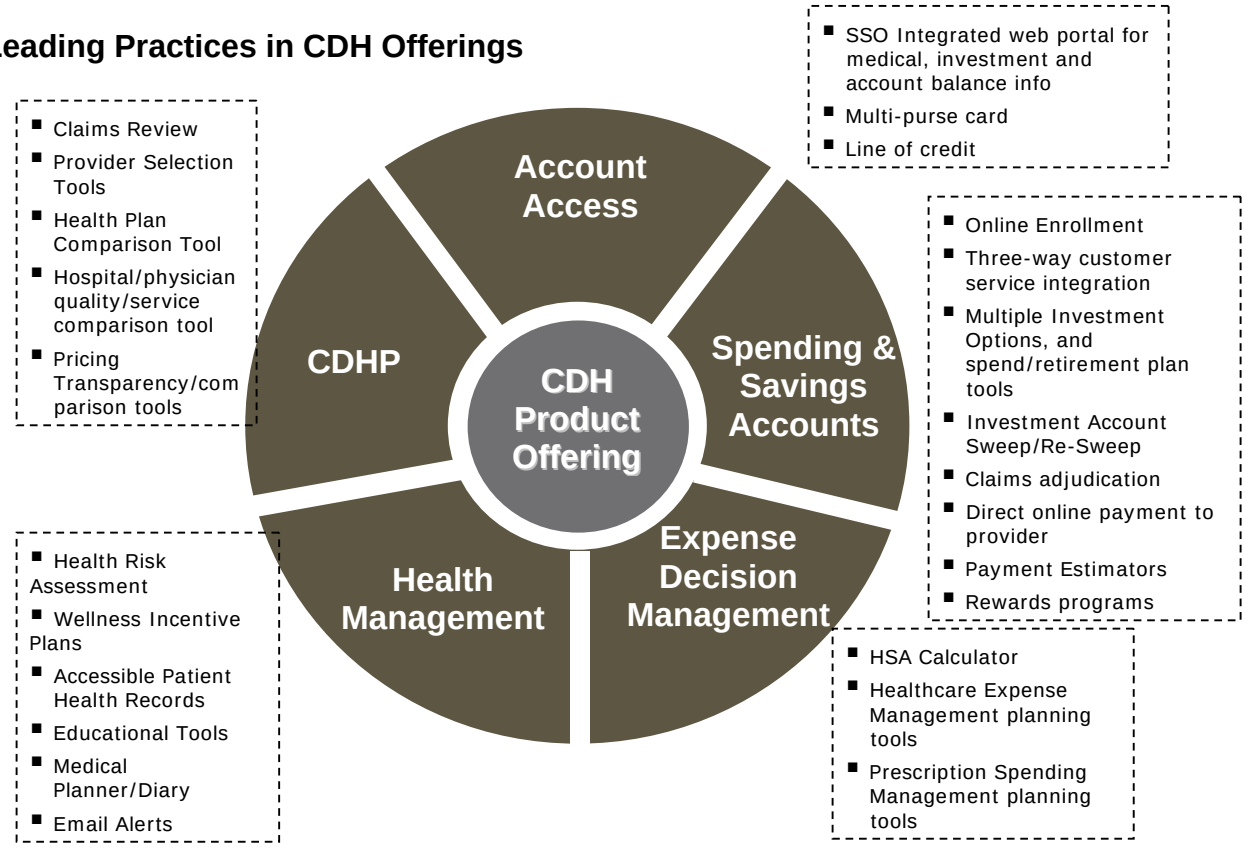
Consumerism in Health, while it has some similarities to consumerism in other areas of the US economy, is a much more sensitive topic for Americans. Make a bad choice in buying a car and you/your family are stuck with a bad method of transportation for a few years. Make a bad choice in health care, and the repercussions can be permanent, chronic or catastrophic. Thus credible, easily accessible consumer information in healthcare is a key missing component in many Consumer Driven HealthCare efforts.

If we can supply the tools and information needed by consumers to make *educated* and well informed decisions, we move everyone closer to a broader adoption of CDH in the US. These tools should also drive a greater *ease* in gaining/using this information, and generate an increased *energy* from the employers and government groups driving this adoption.

As employers and consumer groups have asked what they should seek from those supplying services in health and the associated financial accounts, BearingPoint created an outline of market leading practices. Below is a sampling of leading practices in CDH, focused on the consumer and their needs to drive adoption.

## Leading Practices in CDH Offerings

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# Toward Free-Market Health Care

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Our health care sector must change to meet the challenges of a 21st century economy. Consumers, not just in the United States but in all developed countries, are demanding a much greater role in decisions involving their health care.

America can lead the way in creating a health care system that fits our 21st century economy, but public policy changes are needed to lead us in a new direction.

- For the past six years, the health sector has been introducing patient choice and competition into a system that had been largely dominated by top-down, centralized management.

- Competition is working, but the new leadership in Congress is setting a clear agenda that involves expanding government health care programs and cutting back the initiatives begun over the past several years to bring more competition and patient choice into private and public programs.

- Incentives work, and competition works. What we need to do is engage the power of consumers to transform our health sector to become more efficient, more responsive to consumer needs, and more affordable.

**Innovative Solutions**

The health care initiative that President Bush offered during his State of the Union address in 2007 could usher in the changes that would continue to make the U.S. the leader in quality health care while addressing the growing problem of the uninsured and middle-class anxiety about high health costs. The President would give families the opportunity to own health insurance that is portable from job to job, and he would free up some of their tax money to help them buy the coverage.

The White House estimates his plan also would give a tax cut to 100 million working Americans and provide health insurance to up to 9 million more Americans without any new long-term costs to the federal treasury. The dynamic changes in the marketplace for healthinsurance would transform the system to offer health insurance that is more affordable, flexible, and portable.

The centerpiece of Mr. Bush's plan is a new standard deduction for health insurance. It would be available to any taxpayer who buys qualifying health insurance. Families would get a new $15,000 standard tax deduction, and individuals would get $7,500. You need not itemize and will get the full deduction even if the policy you buy costs less as long as it meets certain minimum requirements for catastrophic coverage. Families earning $50,000 a year could save more than $4,300 in income and payroll taxes and use the tax savings to buy health insurance.

*The above was excerpted from Heritage Lectures, Number 1019, Published by the Hertiage Foundation, May 4, 2007*

# Key to HSA Growth is Getting off to a Strong Start

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Consumer Driven Health Plans, especially those paired with Health Savings Accounts have the potential to transform the way we pay for healthcare in much the same way as 401(k) plans have changed the way that we save for retirement. Although the HSA-compatible plan design is only a few years old, the early growth of HSAs in the small and mid-sized employer market is starting to look reminiscent of the early growth of 401(k) plans over twenty years ago. However, if the HSA is ever to enjoy the dominant position in the health insurance market that's been attained by its retirement plan cousin, it will be necessary to overcome some widely-held misconceptions about HSAs and CDHPs. In particular, these plans must be designed to address the commonly voiced criticism that HSAs are little more than the latest employer cost-shifting ploy that only benefits the young, the healthy and the wealthy. Ultimately, it will fall to employers to design and market these plans to their employees in a way that will have broad-based appeal.

One key to achieving wider employee acceptance of HSAs is to have a relatively high voluntary enrollment rate in the year of their initial introduction. This helps position the HSA as a core employee benefit, rather than a "fringe" offering that only appeals to a few. While there is no magic number that will bring immediate credibility, an enrollment rate of at least 15% to 20% in the first year is probably necessary in order to establish the HSA alongside the PPO and HMO as a core health plan option. Unfortunately, too often employers have introduced HSAs only to find that fewer than 5% of their employees enroll in the first year. Invariably the reasons for this low enrollment rate can be traced back to problems in two areas; plan design and plan communications.

However, it is possible to design and communicate the benefits of an HSA plan in a way that will be widely accepted by employees with diverse healthcare needs. Consider these results from the first-time introduction of HSAs at Sperian Protection, a nationwide manufacturer of Personal Protective Equipment headquartered in Smithfield, Rhode Island. Even though none of the company's employees had prior experience with HSAs, 274 employees (about 23% of all employees enrolled in the company's health plans) selected the new HSA plan over the more familiar PPO option when it was offered in late 2006. More remarkable was the fact that most of those who selected the HSA did not fit the usual profile of what conventional wisdom tells us a typical HSA enrollee looks like (young, healthy and wealthy):

- **Age:** 69% of the HSA participants were over age 40 and 33% were over age 50. (Only 9% were under age 30);

- **Income:** 52% of the HSA participants earned less than $50,000 per year and 34% earned less than $30,000 per year (Only 26% earned more than $75,000 per year);

- **Health Status**: 14% of the HSA enrollees had at least $1,000 in health claims in the prior year (compared with 16% of the total employee population) while 4% of the HSA enrollees had claims in excess of $5,000 in the prior year (compared with 5% of the total employee population).

Sperian achieved these results by first designing an HSA plan that employees would want and then communicating the benefits of the new plan in a simple, straightforward and understandable way. Their insights gained about plan design and communications can be easily replicated by any employer.

*Michael Vittoria continued*

**Plan Design: Follow the "4 C's" of Health Insurance**

Through a series of employee focus groups held at major locations across the United States in the spring of 2006, Sperian learned that most employees weighed four key attributes of a health plan when choosing a health insurance option. These attributes, Coverage, Cost, Convenience and Cash Flow ultimately became known as "The 4 C's of Health Insurance" and formed the foundation upon which the new HSA plan design was built:

- **Coverage** (including access to the broadest possible network of healthcare providers with the least restriction on the types of services that are covered by the plan);
- **Cost** (including deductibles, co-payments, coinsurance and the weekly payroll deduction);
- **Convenience** (the ease of use of the plan with minimal forms to fill out and records to keep);
- **Cash Flow** (the ability to pay-as-you-go for out-of-pocket healthcare expenses without unexpected surprises).

A consistent pattern emerged when the focus group results were compiled. Eighty-three percent of the participants ranked some combination of Coverage and Cost as either number 1 or 2 on their list of key attributes. Nearly the same percentage (80%) placed Convenience as either 3 or 4. An even higher percentage (86%) had Cash Flow as 3 or 4 on their list. As a result, Sperian learned that *employees wanted access to comprehensive coverage at a reasonable cost and if it was necessary to trade off some convenience and deal with an occasional cash-flow issue in order to maintain coverage and cost, they would be willing to do so*. Essentially this was a description of what an HSA-type of health plan might look like.

Armed with the information from the focus groups Sperian designed their HSA plan using the 4 C's model. First, they decided to use the same nationwide Blue Cross network for both the PPO and HSA options. This gave employees in either plan access to the same network of physicians, hospitals and pharmacies and covered the same services so that *everyone had access to the same quality of care* (the "Coverage" issue). "Cost" differences between the PPO and HSA were negated (as were perceptions of "cost shifting") by balancing the weekly payroll deductions, plan deductibles and the company contribution to the employee's HSA so that the *employee's total cost came out about the same* under either the PPO or HSA option if they incurred a major expense such as a hospitalization or if they routinely took expensive medication for a serious illness or a chronic condition. This gave HSA participants the security of knowing that they were protected against high-dollar claims under a worst-case scenario while also giving them the opportunity to save money (when compared with the PPO plan) through lower payroll deductions and the company HSA contribution. Potential "Cash Flow" exposure was minimized by making the full company HSA contribution ($250) in a lump sum during the first week of January.

Addressing the "Convenience" factor required a little more creativity. For all of the benefits of CDHPs in general, and HSAs in particular, the big knock on these plans is that they require more work on the part of a participant than simply walking into a doctor's office, plunking down a membership card and a small co-pay and not caring after that what gets done or how much it will cost. To help ease potential employee frustrations as they began using their HSA, Sperian worked with their TPA to introduce what they now call ***"Concierge Service."*** Borrowing from the model of the hotel concierge, the TPA has one person who does nothing but work with Sperian's employees to help them manage their plan, including calling doctors' offices and hospitals if necessary to directly assist with billing questions or problems.

**Communication: Keep it Straightforward and Understandable**

There is a common perception that in order to have a successful HSA launch, you need to have a big communications campaign that inundates employees with all of the details about how an HSA works. In fact, it is the simpler campaign that will probably be more effective. In Sperian's case, the insights gained from the focus groups also resulted in a complete redesign of their benefits communications. The three things that ultimately had the biggest impact on HSA enrollment were the following:

*Michael Vittoria continued*

1. The term “High Deductible Health Plan” was completely eliminated from the benefits vocabulary;
2. The health insurance election was transformed into a consumer purchasing decision;
3. The protection provided by the HSA design was emphasized in the communications rather than the tax savings.

The first thing that Sperian knew had to go was any reference to a “High Deductible Health Plan.” Instead, it was replaced the term ***up-front deductible*** which is a more accurate description of how the HSA plan actually works. It also makes for a more straightforward and understandable employee communication. When employees were told that they would pay an up-front deductible of $1,100 (and the plan would then pay 100% of their remaining expenses) they knew exactly how much they were going to be expected to pay and when they would have to pay it. They could then decide for themselves whether $1,100 was a “high” deductible or not, given the total value of the health benefit that they were purchasing.

Rather than relying on the books of printed material typically provided to employees during open enrollment, Sperian worked with their TPA to design a series of colorful one-page communication pieces that grabbed the attention of employees and got them thinking about the financial decision involved in choosing a health plan. Using eye-catching headlines such as **“Did You Get Your Money’s Worth From Your Health Plan Last Year?”** and **“It’s Your Money to Keep, Spend or Save”** the goal was to get employees to start thinking about their choice of health plans as they would any other major purchase costing thousands of dollars so that they made their enrollment decision in terms of the *total value* of their plan (the 4 C’s).

The last thing that was done differently was to emphasize the *protection* offered by an HSA plan rather than focusing on the tax savings. That’s not to say that the tax benefits of HSAs were ignored in the communications, they were just kept in the proper perspective. Tax savings are a great benefit for those with higher incomes, which is probably how HSAs got the reputation that they are only good for the rich. But, the average person buys health insurance for protection, not for tax breaks and this is one area where an HSA can really shine if it is properly presented. A big advantage of the Sperian plan design is that it pays for 100% of covered expenses once the up-front deductible is satisfied. As it was explained to the employees, it meant that they always knew with absolute certainty what their worst-case scenario would be. The idea that the HSA deductible gave them a “not to exceed cost” for health expenses had a powerful appeal to many employees, especially those who described themselves as “risk averse” and normally inclined to pay the higher weekly PPO premiums for the “peace of mind” that it provided.

HSAs can be a viable health plan option if they are designed right and communicated well. Whether these plans fully realize their potential to transform the way we finance healthcare in the United States will largely depend on employers to make them an attractive option for their employees.

# Consumer-Driven Spending or Consumer-Driven Care — Which Is It?

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Two of the core elements of consumer-driven plans — tax-sheltered spending accounts and high deductible coverage — implicate health care spending. The theory is that consumer-driven spending arrangements reduce the role of third party payment and increase consumer power over the provider reward system. But consumer-driven *spending* arrangements are not enough to bring about consumer-driven *care*.

Consumer-driven care should be highly individualized care, driven by unique individual needs, not by the idiosyncrasies of providers or by the dictates of third party payers. Yet, consumer-driven care is missing from the marketplace. Medical practice in its current form is vendor-driven. It lacks the standards and tools needed to deliver individualized, consumer-driven care in a systematic, reproducible, affordable manner.

Consider what happens when a physician first encounters a consumer with a medical problem for diagnosis or treatment. Were the encounter driven by the *consumer's* needs, the physician's initial data collection and analysis would not vary from one physician to another. Yet, initial data collection and analysis in fact vary enormously depending on which physician the consumer sees first. Different physicians ask different questions about the consumer's medical and family history, they make different findings in the physical examination, they order different laboratory tests and they reach different conclusions even when considering the same data. This variation at the front end of medical decision making is driven by provider idiosyncrasies, not individual consumer needs. Those individual needs continue to be neglected at the back end, when treatment decisions are made. At that stage, treatments are very often not individualized to the unique needs of each consumer. Instead, physicians fall back on limited personal knowledge, or customary local practice, or one-size-fits-all dictates of third party payers, or "evidence-based" standards derived from large population studies.

A true consumer-driven system would take precisely the opposite approach to decision making. The front end would not be variable but highly standardized; at the back end decisions would become individualized.

All providers would begin by following pre-defined minimum standards for initial investigation of specific medical problems presented by consumers. To diagnose chest pain, for example, each provider would collect and analyze the data known to be the most useful for cost-effectively identifying possible causes of chest pain. This requires considering more than 100 possible causes of that symptom, collecting approximately 490 items of data needed to identify which of those diagnostic possibilities might account for chest pain in a given individual, and analyzing all that data in light of vast medical knowledge. The required data items are simple and inexpensive, collected in large part from the consumer’s own responses to a computerized questionnaire. Because this standardized data collection and analysis far exceeds the capacities of the physician's mind, software guidance tools designed to elicit patient data and integrate it with medical knowledge are essential (and have been developed).

After this standardized initial investigation, consumer-driven care would become increasingly variable from one consumer to another, as individual differences emerge from detailed data. Careful analysis of the chest pain symptom, its diagnosis and possible treatment options would reveal that different consumers labeled with the "same" diagnosis, and for whom a standard "evidence-based" treatment seems appropriate, in fact may have very different personal needs, not to mention different preferences. Diagnostic labels and standard treatment guidelines are based on a few elements different individuals have in common, while consumer-driven decisions must take into account innumerable differences among those individuals.

*Lincoln Weed, continued*

In a truly consumer-driven environment, uniform "evidence-based" standards of the best treatment for a given diagnosis would be seen as a crude substitute for high-quality, individualized care. Consumers themselves, using information tools designed to organize their data and integrate it with medical knowledge, and possessing intimate personal knowledge of their own medical conditions, would be seen as medical decision makers. Physicians would be seen as expert service providers, not as repositories of knowledge or as decision making oracles. Medical "knowledge" itself would be seen as only a provisional approximation of medical reality for each individual consumer. Structured electronic medical records documenting that reality for every consumer would be used to organize caregiving around consumer needs. And clinical researchers would study those records to continuously improve medical knowledge.

Consumer-driven health care as described above faces obstacles in the marketplace that will not be overcome merely with consumer-driven spending arrangements. A primary obstacle is that monopolistic authority over medical decision making is conferred on physicians, who are permitted to rely on their unaided minds for basic information processing. Yet, as the chest pain example shows, individualized care demands information processing far beyond the capacities of the human mind. Software guidance tools provide an escape from this dilemma, but only if new standards of care inform the software's design and use. The necessary standards of care involve enforcing detailed data collection and highly structured data organization in medical records. Yet, those standards of care are incompatible with how physicians are currently educated to function.

The obstacles to consumer-driven care might have been overcome long ago if the medical profession were subject to greater competition. But competition is severely limited. Graduate medical education and credentialing laws block most independent practice by non-physician caregivers. This state of affairs must change if consumer-driven care is to reach its potential. Alternative regulatory schemes need to be developed whereby individual and institutional providers, without the usual dependence on physicians, have greater latitude to innovate in delivery of individualized care, subject to high minimum standards of quality. Education and credentialing would need to change from the current knowledge-based approach to a skills-based approach. In that environment, providers would compete at skillfully and economically providing high quality services chosen by consumers based on objective information in a well-defined, transparent system of care, without dependence on physician-supplied knowledge.

In short, truly consumer-driven, individualized care requires three basic reforms: (1) new standards of care for managing medical information, (2) new information tools (software guidance tools and structured electronic medical records) designed to implement those standards of care, and (3) a new market system for health professional services, based on a new form of medical education and credentialing. The new standards of care and information tools are in large part already developed. (By way of full disclosure, the original developer is the author's father, Dr. Lawrence L. Weed.) For more information, interested readers are invited to review the following web pages and the additional sources they cite:

http://www.pkc.com/papers/economist.pdf
http://www.bmj.com/cgi/content/full/319/7220/1279/DC2
http://books.nap.edu/openbook.php?record_id=5306&page=90
http://www.pkc.com

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