CDHPs + DM = Population Health?

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

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The Willie Sutton Theory of CDHP Success

Long-term, success is dependent on making CDHPs attractive to people with chronic diseases & conditions.
Outline of the Presentation

I. Why is DM Important to CDHPs?
II. CDHP Background
III. CDHPs Have Aspects That Are “DM Friendly”
IV. However, CDHPs Have Aspects That are NOT “DM Friendly”
V. Two Scenarios of How CDHPs and DM Come Together
VI. Developing “DM Friendly” CDHPs
VII. Conclusion
Our Thesis in a Nutshell

• Two purchasing trends are hot among employers:
  – Consumer Driven Health Plans (CDHPs)
  – Disease Management (DM)
• Although these purchasing trends arose in isolation, they are merging.
• CDHPs have some “DM friendly” features and some that are NOT so “DM friendly”.
• Under current regulations, Health Reimbursement Arrangements (HRAs) and Health Savings Accounts (HSAs) have vastly differing implications for DM.
• At this point, it is not clear ultimately how CDHPs and DM will come together. We see the potential for two divergent scenarios
  – 1) DM + CDHPs = Population Health, or
  – 2) DM + CDHPs = Hell in a Handbasket.
• Today’s reality is:
  – HRAs allow active integration of DM.
  – HSAs require legislative changes to be DM friendly.
• Information, Tools, and Incentives are the key mechanisms to facilitate appropriate integration of DM and CDHPs.
“Extra! Extra!” Recent Developments Affecting Status of DM in CDHPs!!!

1) White House acknowledges need for legislation to reform "comparability" contribution requirements of HSAs. Should this be interpreted as:
   a) a natural, free market evolution of CDHPs?
   or
   b) Acknowledgement that the purist, hard line view of CDHPs -- "we want consumers to experience the true, full costs of health care" -- is flawed?

2) Even further polarization after Bush's State of the Union – some editorials cry out "HSAs are evil"

3) Recent Treasury Regs easing comparability requirements are a good start, but.....
I. Why is DM Important to CDHPs?
CDHPs + DM = Population Health?

$\text{DM}$

$\text{CDHPs}$

$\text{Claimant Percentile}$

$0 \quad 10 \quad 20 \quad 30 \quad 40 \quad 50 \quad 60 \quad 70 \quad 80 \quad 90 \quad 100$

$\text{Per Claimant Per Yr.}$

$\text{\$0} \quad \text{\$1,000} \quad \text{\$2,000} \quad \text{\$3,000} \quad \text{\$4,000} \quad \text{\$5,000} \quad \text{\$7,500} \quad \text{\$10,000}$

$\text{\$100,000}$
Arguable criticisms of CDHPs relate back to chronic care and high cost patients....

• Can CDHPs save costs?
  5% of people = 52% of cost
• Care for chronic patients can quickly exceed the deductible, tempering incentives to watch costs
• Lack of timely, accurate and usable information
• Risk of deferring necessary care or reducing adherence to clinical protocols
• Risk of fragmenting the insurance risk pool

Source: adapted from Protecting Consumers in an Evolving Health Insurance Market, NCQA, 2006, p. 6
II. CDHP Background
Employers have 2 primary motivations for shifting toward CDHPs:

1) **Cost control** by shifting cost sensitivity to consumers. Employers want employees to experience the “true cost” of health care.

2) **Encouraging informed consumerism** by providing employees with financial incentives, health care information & tools to become more cost accountable and health outcomes conscious.
There is Potential for Rapid Adoption of CDHPs

CDHP enrollment will reach 12 million members — almost 7% of the commercial market — in 2007.

Consumer-directed health plans will account for $88 billion in 2007, a sixfold increase over 2005.

Total annual revenues from consumer-directed health plans, in premiums and premium equivalents paid by employers and employees.

[Forrester, July 2005]
HRA vs. HSA: Lots of HSA “Buzz” but Employers May Favor HRAs

<table>
<thead>
<tr>
<th></th>
<th><strong>HRA</strong></th>
<th><strong>Description</strong></th>
<th><strong>HSA</strong></th>
<th><strong>Description</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ownership</strong></td>
<td>Employer</td>
<td>Control by employer; Managed care features allowed</td>
<td>Employee</td>
<td>Employee controls subject to Treasury Regs.; Managed care features not allowed</td>
</tr>
<tr>
<td><strong>Funding</strong></td>
<td>Employer only contributes</td>
<td>Provides for stability in funding levels</td>
<td>Employer and employee can contribute</td>
<td>Employee financial commitment increases their stake in health care utilization</td>
</tr>
<tr>
<td><strong>Accounting treatment of funds</strong></td>
<td>Employer responsibility</td>
<td>Considered an unfunded liability -- employer only pays for services used</td>
<td>Employer funds must be paid into the HSA</td>
<td>Real dollars are paid out on a regular schedule that the employee takes with them</td>
</tr>
<tr>
<td><strong>Potential for reducing discretionary spend</strong></td>
<td>Yes--moderate</td>
<td>Employee has financial incentive with employer $s and a managed care system</td>
<td>Yes--higher</td>
<td>Employee has financial incentive with their own $s and no managed care system</td>
</tr>
<tr>
<td><strong>Potential for inappropriate utilization/lowered compliance</strong></td>
<td>Yes--moderate</td>
<td>Employee has some financial incentive to reduce utilization to pay for other services</td>
<td>Yes--higher</td>
<td>Employee has a stronger incentive to reduce utilization to pay for other services or build up fund assets</td>
</tr>
<tr>
<td><strong>Disease management offering/ integration</strong></td>
<td>Moderate to high</td>
<td>Employer controls funds and can provide first dollar coverage for DM</td>
<td>Uncertain</td>
<td>Current Treasury guidelines penalize employers offering DM due to requirement of comparable contributions</td>
</tr>
</tbody>
</table>
III. CDHPs Have Aspects That Are “DM Friendly”
Employers Value DM as One of the Most Effective Cost-Containment Strategies

Distribution of Firms’ Opinions on the Effectiveness of the Following Cost Containment Strategies, 2005

- **Disease Management**: 14% Very Effective, 38% Somewhat Effective, 17% Not Too Effective, 24% Not At All Effective, 7% Don’t Know
- **Higher Employee Cost Sharing**: 12% Very Effective, 46% Somewhat Effective, 16% Not Too Effective, 22% Not At All Effective, 4% Don’t Know
- **Consumer-Driven Health Plans (e.g., high-deductible plan combined with a health savings account)**: 16% Very Effective, 45% Somewhat Effective, 15% Not Too Effective, 17% Not At All Effective, 7% Don’t Know
- **Tighter Managed Care Networks**: 7% Very Effective, 37% Somewhat Effective, 22% Not Too Effective, 21% Not At All Effective, 12% Don’t Know

Some Aspects Of CDHPs Are Supportive Of DM

CDHPs and DM are eye-to-eye about the need for high-quality:

1) Consumer information
2) Consumer tools (supported by a robust, customized technological infrastructure)
3) Consumer incentives

Potential for appropriate cost reduction
CDHP/DM Harmony

• Accurate, reliable information is a key to appropriate health care decisions by consumers
  – Evidence based guidelines
  – Quality & outcomes information about providers
  – etc.

• Patients need training in self-management approaches

• Ideally, information should be personalized based on patients’ knowledge, skills, beliefs, motivations, health literacy, and availability of psychosocial support

• Information delivery should be enhanced through a robust, user-friendly technological infrastructure
  – Shared decision making tools
  – Interactive web sites
  – etc.
### Most Insured Don’t Have Quality and Cost Information to Make Informed Choices

<table>
<thead>
<tr>
<th>Health plan provides information on quality of care provided by:</th>
<th>Comprehensive</th>
<th>HDHP/CDHP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>14%</td>
<td>16%</td>
</tr>
<tr>
<td>Hospitals</td>
<td>14</td>
<td>15</td>
</tr>
</tbody>
</table>

<table>
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<th>Health plan provides information on cost of care provided by:</th>
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<tr>
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<td>16</td>
<td>12</td>
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<tr>
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Of those whose plans provide info on quality, how many tried to use it for:

<table>
<thead>
<tr>
<th>Doctors</th>
<th>Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>42</td>
<td>25</td>
</tr>
</tbody>
</table>

Of those whose plans provide info on cost, how many tried to use it for:

<table>
<thead>
<tr>
<th>Doctors</th>
<th>Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>14</td>
</tr>
</tbody>
</table>

IV. However, CDHPs Have Aspects That are NOT "DM Friendly"
Some Aspects Of CDHPs Are NOT Supportive Of DM

Where CDHPs and DM are NOT eye-to-eye: Increased cost sharing creates the potential for patients to:

1) Defer needed care
2) Reduce adherence to prescribed treatment regimens

Potential for inappropriate cost reduction
Enrollees of HDHP/CDHPs Are More Likely to Delay or Avoid Getting Health Care Due to Cost

Percent of adults 21-64

<table>
<thead>
<tr>
<th></th>
<th>Comprehensive</th>
<th>HDHP</th>
<th>CDHP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>17</td>
<td>31</td>
<td>35</td>
</tr>
<tr>
<td>Health Problem</td>
<td>21</td>
<td>31</td>
<td>40</td>
</tr>
<tr>
<td>&lt;$50,000 Annual Income</td>
<td>26</td>
<td>42</td>
<td>48</td>
</tr>
</tbody>
</table>

RAND Study – Increasing Co-Pays Reduces Utilization of Rx

The percentage change in per-member annual days supplied when co-payments increase by 100% in the average 2-tier plan is shown. This plan has retail co-payments of $6.31 for generics and $12.85 for brand-name drugs and has an index value of 168. For each chronically ill subpopulation, we estimated the change in drug use within class (eg, use of antidepressants by depressed patients) and outside of class (eg, use of all other medications by depressed patients) when co-payments increase by 100%. NSAIIDs indicates nonsteroidal anti-inflammatory drugs.

[JAMA; May 19, 2004]
Harris Interactive Survey – HDHP Consumers Have More Compliance Problems

<table>
<thead>
<tr>
<th>Treatment compliance problems (due to cost)</th>
<th>Other Privately Insured* %</th>
<th>HDHP** %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Had a specific medical problem but did not visit a doctor</td>
<td>17</td>
<td>33</td>
</tr>
<tr>
<td>Took a medication less often than I should have</td>
<td>14</td>
<td>29</td>
</tr>
<tr>
<td>Did not fill a prescription</td>
<td>15</td>
<td>28</td>
</tr>
<tr>
<td>Did not receive a medical treatment or follow up recommended by a doctor</td>
<td>17</td>
<td>28</td>
</tr>
<tr>
<td>Did not get a physical or annual check-up</td>
<td>19</td>
<td>25</td>
</tr>
<tr>
<td>Took a lower dose of a prescription than my doctor recommended</td>
<td>15</td>
<td>19</td>
</tr>
</tbody>
</table>

* Currently insured in employer-sponsored or self-purchased plan (not high deductible)
** Currently enrolled in high deductible health plan

Source: Strategic Health Perspectives, Harris Interactive Inc., 2004
How Big a Deal is Adherence to Prescribed Treatments?

“Increasing the effectiveness of adherence interventions may have a far greater impact on the health of the population than any improvement in specific medical treatments.”

World Health Organization, 2001
HRAs vs. HSAs Have Vastly Different Implications For DM

• Health Reimbursement Arrangements (HRAs) allow employers more flexibility to structure benefits that are “DM friendly”.
  – Employers have the option to structure first dollar coverage for a wide range of benefits. First dollar coverage allows for employers to pay for specific services e.g., preventive care, DM, with pre-deductible dollars.
  – HRAs provide a transitional approach which is more appealing to larger, more sophisticated companies.
• Health Savings Accounts (HSAs) have allowed employers **virtually no flexibility** to structure benefits that are chronic care and/or “DM friendly”.

  – The underlying philosophy of HSAs is focused on exposing employees to “true, full costs” of health care.
  – HSA regulations have allowed very limited flexibility for preferential benefit structures, e.g., benefit structures that provide first dollar coverage and/or incentives for DM or related programs. HSAs allow minimal discretion to differentiate coverage among different health care components, e.g., Rx, hospitals, doctors, etc.
  – HSA regulations allow for first dollar coverage of preventive care. However, DM is not defined as preventive care.
  – Employers generally view **HSAs as a more potent CDHP vehicle** because the savings feature encourages employees to view funds as “my money”.

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While Treasury Regs Require “Comparable” Contributions to Employee HSAs by Employers....

- “Employer contributions to an HSA based on an employee’s participation in health assessments, disease management program or wellness program do not have to satisfy the comparability rules if the employee may elect to receive that payment in currently taxable cash rather than having a nontaxable contribution to the HSA
  - Cafeteria plan nondiscrimination rules also apply”

- Translation: Employers are allowed to fund DM for the 10% who need it only if they give an equal amount of cash to the other 90%

- Recent Treasury Regs easing comparability requirements are a good start, but.....
....President Bush is On Record Supporting Legislation to Allow Employers to Make Higher HSA Contributions to Chronically Ill Employees

The President Supports Allowing Employers To Make Higher Contributions To The HSAs Of Chronically Ill Employees. Under current law, employers must contribute the same amount to each employee's HSA. This prevents employers from providing extra help to their chronically ill employees – employees who are more likely to use their HSAs to pay for their higher-than-average out-of-pocket expenses. Permitting employers to make higher contributions to HSAs of chronically ill employees will help those workers fund their HSAs and pay their out-of-pocket expenses tax-free through their accounts.
V. Two Scenarios of How CDHPs and DM Come Together
Two Scenarios of DM and CDHPs

• **DM + CDHPs = Population Health**
  – Creating empowered, knowledgeable consumers
  – Benefit design encourages chronic care: lower copays, first dollar coverage of DM tools (drugs), appropriate utilization of drugs
  – Long-term adherence to evidence based treatment
  – HRAs

• **DM + CDHPs = Hell in a hand basket**
  – Cost reduction at any cost
  – Benefit design indifferent to chronic illness
  – Short-term cost shifting to consumers
  – HSAs (as currently structured)
Today’s Reality

• HRAs allow active integration of DM.
• Status of DM in HSAs in a state of limbo due to:
  – White House acknowledgement that “comparability” contribution requirements need to be changed.
  – Need to actually enact proposed changes. Can this happen in light of party (R vs. D) polarization?
  – Need to develop evidence re: effects of changing the comparability contribution requirements – this will take years.
VI. Developing “DM Friendly” CDHPs
Creating DM Friendly CDHPs

- Modify comparability rules to allow larger contributions for HSAs for the chronically ill
- Allow pre-deductible funding for
  - DM services
  - Drugs for chronic care
- Lift contribution limits to HSAs – allow individuals and employers to budget up to out-of-pockets amounts

- ....and more
The I,T,I’s of Disease Management
Friendly CDHPs

- **Information** that is credible, accurate, and usable
- **Tools** for optimal utilization of consumer information
- **Incentives** for participation and behavior change
I, T, I Examples

• Information
  – Healthwise consumer information
  – Mayo HealthQuest
  – Micromedex

• Tools
  – Lumenos’ coaching resource
  – Health Dialog’s “just in time” information
  – Healthwise information therapy
  – Remote monitoring technology

• Incentives
  – Medco waiving deductibles for preventive medications
  – Benicomp Advantage providing $500 credit for lifestyle choices
  – Aetna provision of preventive drugs
  – Pitney-Bowes removal of financial barriers to appropriate drug utilization

• ...and dozens of other examples....
VII. Conclusion
So, the next time you read a headline that says

“Studies show Acme CDHP reduces costs by 13.47%”

Ask

Was the reduction in costs appropriate or inappropriate?
Riedel & Associates Consultants, Inc. (R&ACI)

- John E. Riedel is the Founder and President of R&ACI.
- R&ACI has been providing strategic consultation to employers, managed care firms, pharmaceutical companies, hospitals and provider groups, and managed care vendors in the area of demand management for nine years.
- Through his employer surveys and training in demand management and health and productivity management John has worked with over 300 of the Fortune 1000 companies.
- Focusing on market research, product positioning, and evaluation design, R&ACI has worked with over 40 clients including Healthwise, Pacificare, Florida Hospital System, Merck-Medco Managed Care, Pharmacia, Sanofi-Aventis, Schering-Plough, American College of Occupational and Environmental Medicine, Pfizer, Quest Communications, Dow Chemical, Glaxo Smith Kline, Integrated Benefits Institute, and 15 Blue Cross and Blue Shield Plans.
Better Health Technologies, LLC

• Vince Kuraitis is founder and Principal of Better Health Technologies
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  -- Samsung Advanced Institute of Technology
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- Medtronic
  -- Neurological Disease Management
  -- Cardiac Rhythm Patient Management
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- Joslin Diabetes Center
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- Disease Management Association of America
- Blue Cross Blue Shield of Massachusetts
- PCS Health Systems
- Varian Medical Systems
- VRI
- Washoe Health System
- S2 Systems
- Corphealth
- Physician IPA
- Centocor