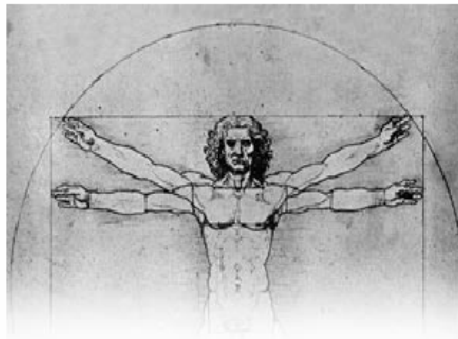


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CDHPs + DM = Population Health?



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*

Hyatt Regency on Capitol Hill
Washington, DC

September 13 - 15, 2006

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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!!!

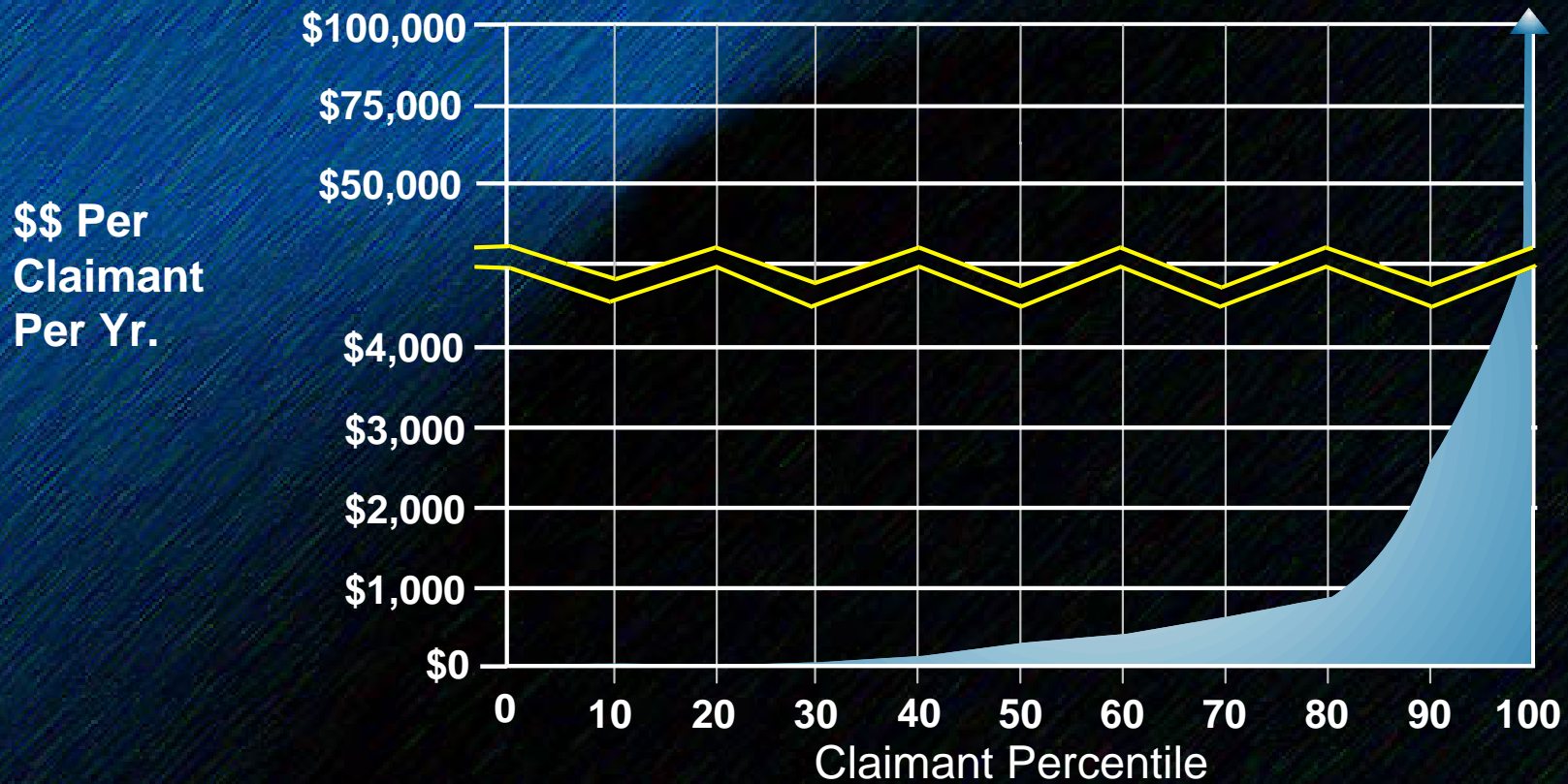


- 1) White House acknowledges need for legislation to reform "comparability" contribution requirements of HSAs. Should this be interpreted as:
 - a) a natural, free market evolution of CDHPs?
 - or
 - b) Acknowledgement that the purist, hard line view of CDHPs -- "we want consumers to experience the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

A blue-tinted photograph of a computer keyboard, mouse, and glasses on a desk. The keyboard is on the left, the mouse is on the right, and a pair of glasses is in the foreground. The background is a dark blue textured surface.

I. Why is DM Important to CDHPs?

CDHPs + DM = Population Health?



DM

CDHPs



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

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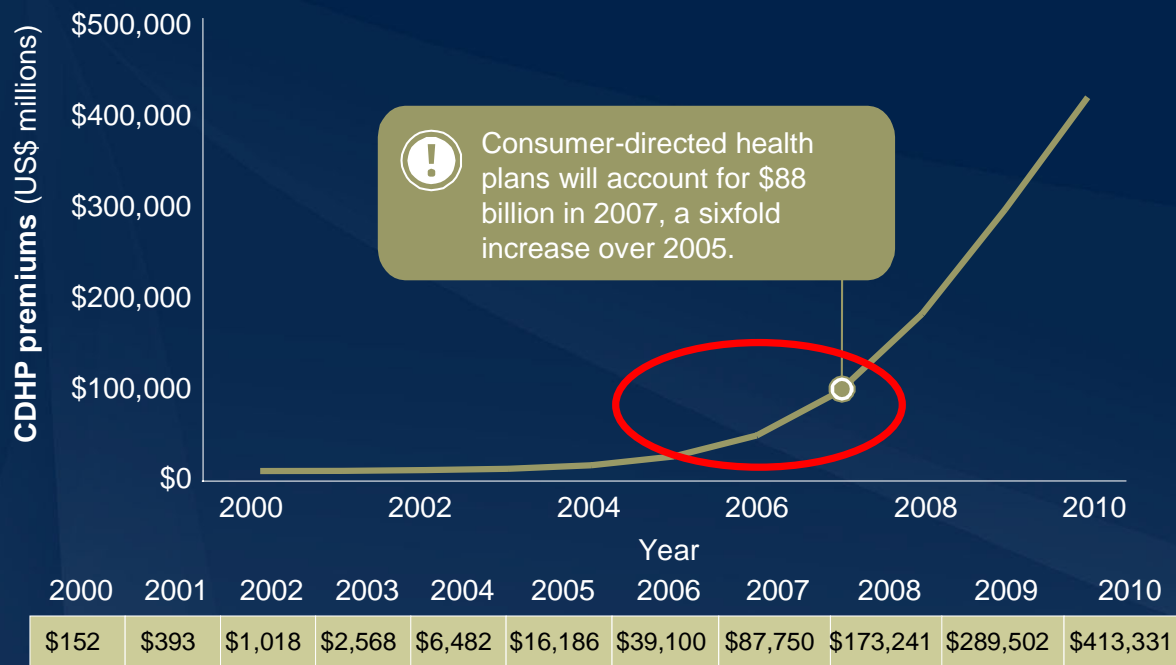
II. CDHP Background

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



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

FORRESTER

HRA vs. HSA: Lots of HSA “Buzz” but Employers May Favor HRAs

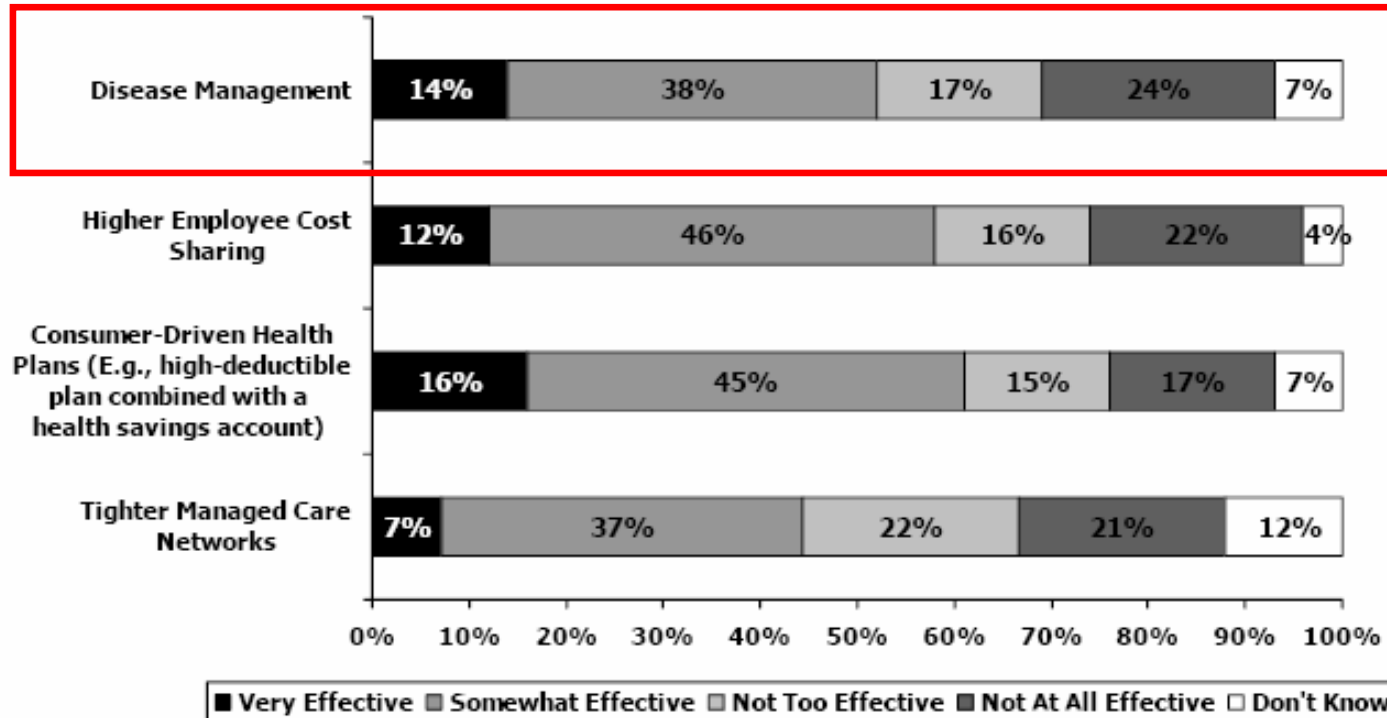
	<u>HRA</u>	<u>Description</u>	<u>HSA</u>	<u>Description</u>
Ownership	Employer	Control by employer; Managed care features allowed	Employee	Employee controls subject to Treasury Regs.; Managed care features not allowed
Funding	Employer only contributes	Provides for stability in funding levels	Employer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

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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



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2005.

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

15

	Comprehensive	HDHP/CDHP
Health plan provides information on quality of care provided by:		
Doctors	14%	16%
Hospitals	14	15
Health plan provides information on cost of care provided by:		
Doctors	16	12
Hospitals	15	12
<hr style="border-top: 1px dashed black;"/>		
Of those whose plans provide info on quality, how many tried to use it for:		
Doctors	42	54
Hospitals	25	45
Of those whose plans provide info on cost, how many tried to use it for:		
Doctors	15	36 (n = 76)
Hospitals	14	32 (n = 76)

Source: P. Fronstin, S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, EBRI Issue Brief, December 2005.





IV. However, CDHPs Have Aspects That are NOT “DM Friendly”

Some Aspects Of CDHPs Are NOT Supportive Of DM

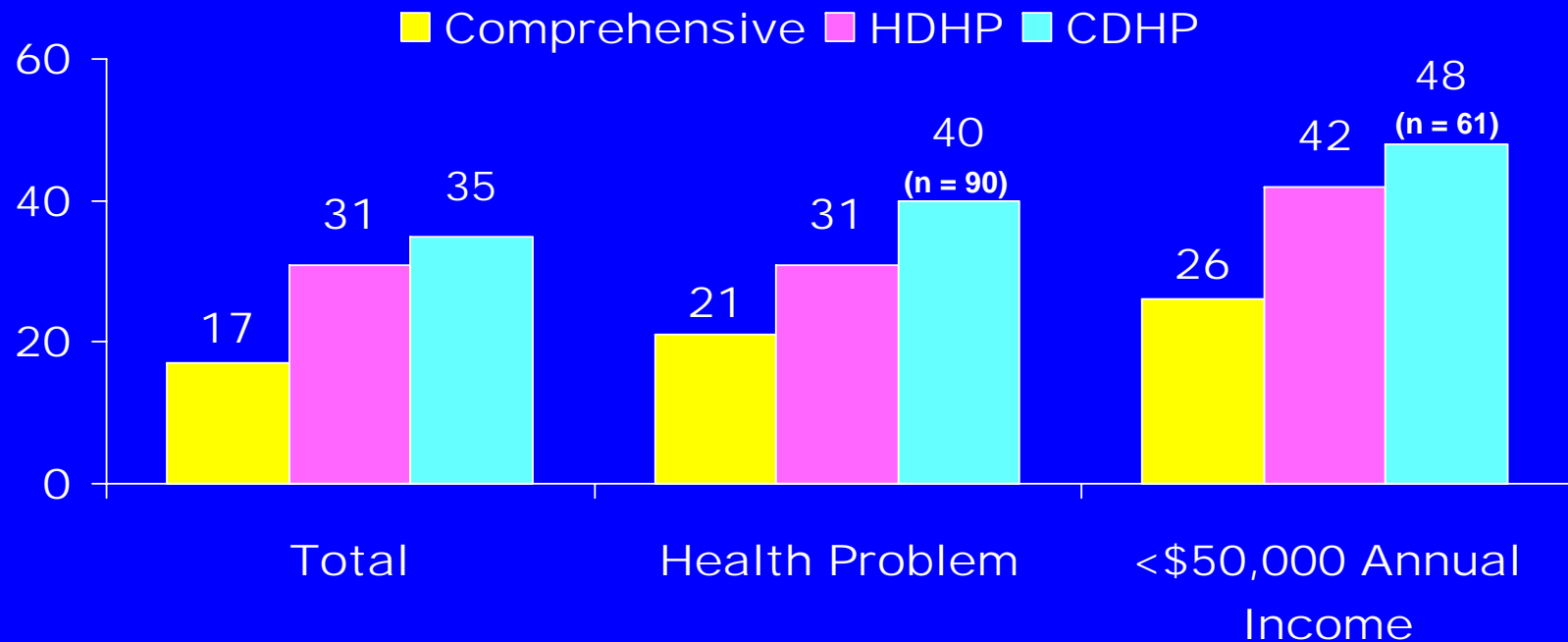
Where CDHPs and DM are NOT eye-to-eye: Increased cost sharing creates the potential for patients to:

- 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

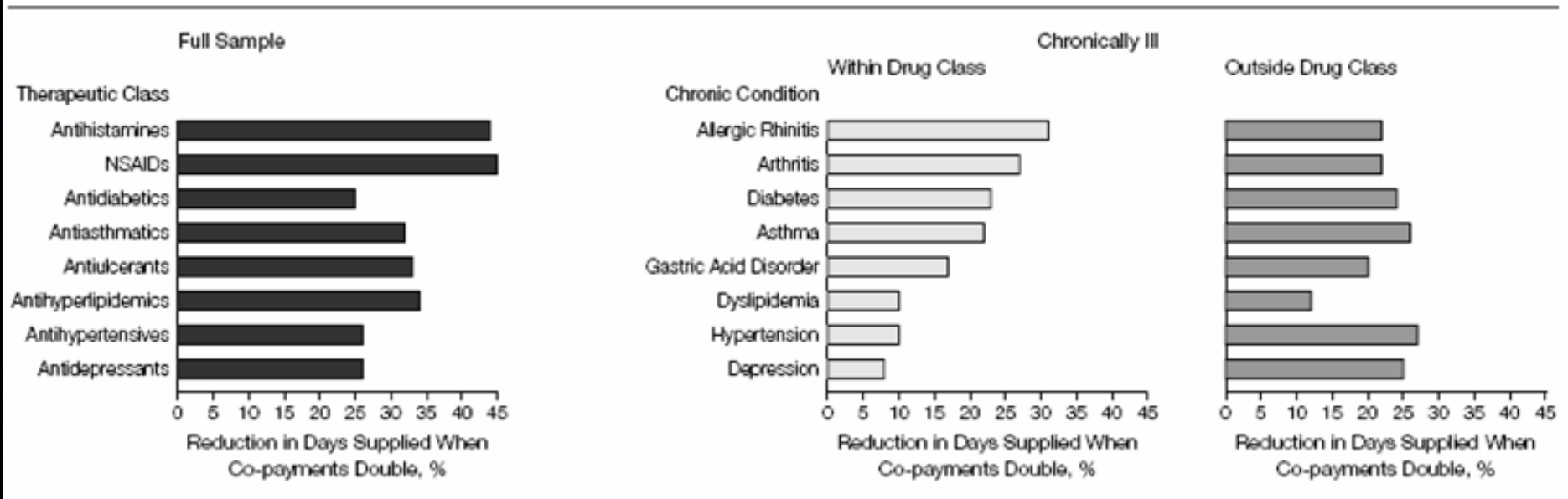


Source: P. Fronstin, S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, EBRI Issue Brief, December 2005.



RAND Study – Increasing Co-Pays Reduces Utilization of Rx

Figure. Predicted Change in Annual Days Supplied When Co-payments Double by Drug Class and Population



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%. NSAIDs indicates nonsteroidal anti-inflammatory drugs.

[JAMA; May 19, 2004]

Harris Interactive Survey – HDHP Consumers Have More Compliance Problems

Treatment compliance problems (due to cost)

	Other Privately Insured* %	HDHP** %
Had a specific medical problem but did not visit a doctor	17	33
Took a medication less often than I should have	14	29
Did not fill a prescription	15	28
Did not receive a medical treatment or follow up recommended by a doctor	17	28
Did not get a physical or annual check-up	19	25
Took a lower dose of a prescription than my doctor recommended	15	19

* 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

[Source: Harris Interactive, 2005]

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”.

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



All About HSAs

U.S. Treasury Department
Washington, DC

November 28, 2005

- “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.

The screenshot shows the White House website interface. At the top, there is a navigation bar with links for President, News, Vice President, History & Tours, First Lady, and Mrs. Cheney. Below this is a secondary navigation bar with links for YOUR GOVERNMENT, KIDS, ESPAÑOL, CONTACT, PRIVACY POLICY, SITE MAP, and SEARCH. The main header features the White House logo and the text 'The White House PRESIDENT GEORGE W. BUSH'. On the right side of the header, there is an 'EMAIL UPDATES' section with a search box and a 'SEARCH' button. Below the header, there is a breadcrumb trail: 'Home > News & Policies > January 2006'. On the left side, there is an 'Issues' section with a list of topics: Education, Energy, Homeland Security, Hurricane Recovery, Immigration, Jobs & Economy, Judicial Nominations, National Security, Pandemic Flu, and Patriot Act. On the right side, there are links for 'Printer-Friendly Version' and 'Email This Page'. At the bottom right, there is a release date: 'For Immediate Release Office of the Press Secretary January 31, 2006'. The main content area displays the title of the article: 'State of the Union: Affordable and Accessible Health Care'.

A blue-tinted photograph of a computer keyboard, mouse, and glasses on a desk. The keyboard is in the upper left, the mouse is in the upper right, and a pair of glasses is in the lower left. The background is a dark blue textured surface.

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.

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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
 - BenicompAdvantage 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....

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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**
- **Creating value for patients and shareholders**
- **Strategy, business models, partnerships**
- **Disease/care management and e-health**
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