



# Will Consumer-Directed Plans Work for People with Chronic Conditions?

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# Overview



- Consumer-driven market review
- Account-based model overview
  - Adverse selection
  - IOM Quality Chasm imperatives
- Challenge of chronic disease(s)
  - What isn't working now
  - Behavior change: risk factors and “compliance” vs “competence”
- Consumer-driven advantage: Incentivized and integrated health strategy
  - Results to date
- Chronic care model revisited
- Future considerations and directions

# Chronic Care Model\*: Consumer/Patient-Driven & “Owned”?



- Self-management
- Decision support
- Delivery system design
- Clinical information systems
- Health care organization
- Community resources

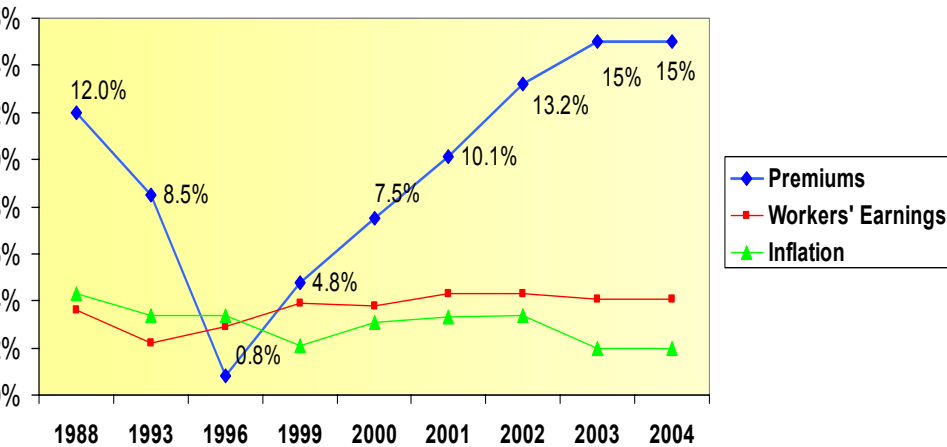
**“Jackson Hole Group reconsiders approach . . .”**

\*Bodenheimer, Wagner, Grumbach JAMA 2002

# Cost Increases Not Sustainable For Employers or Nation



## Increases in Premiums vs. Other Indicators



## Employers are Tweaking Benefits and Increasing Employee Costs

- Increasing & adding deductibles (hospital)
- Increasing copays (office visit, Rx)
- Moving away from copays
- Increasing contributions
- Decreasing benefits

Kaiser/HRET and KPMG, 2001  
Hewitt 2004 projections  
2004 earnings and inflation estimated

*Growing realization that a fundamental change is needed...*

*Legislative/policy changes will help transform the market...*

# Consumer Driven Care Today



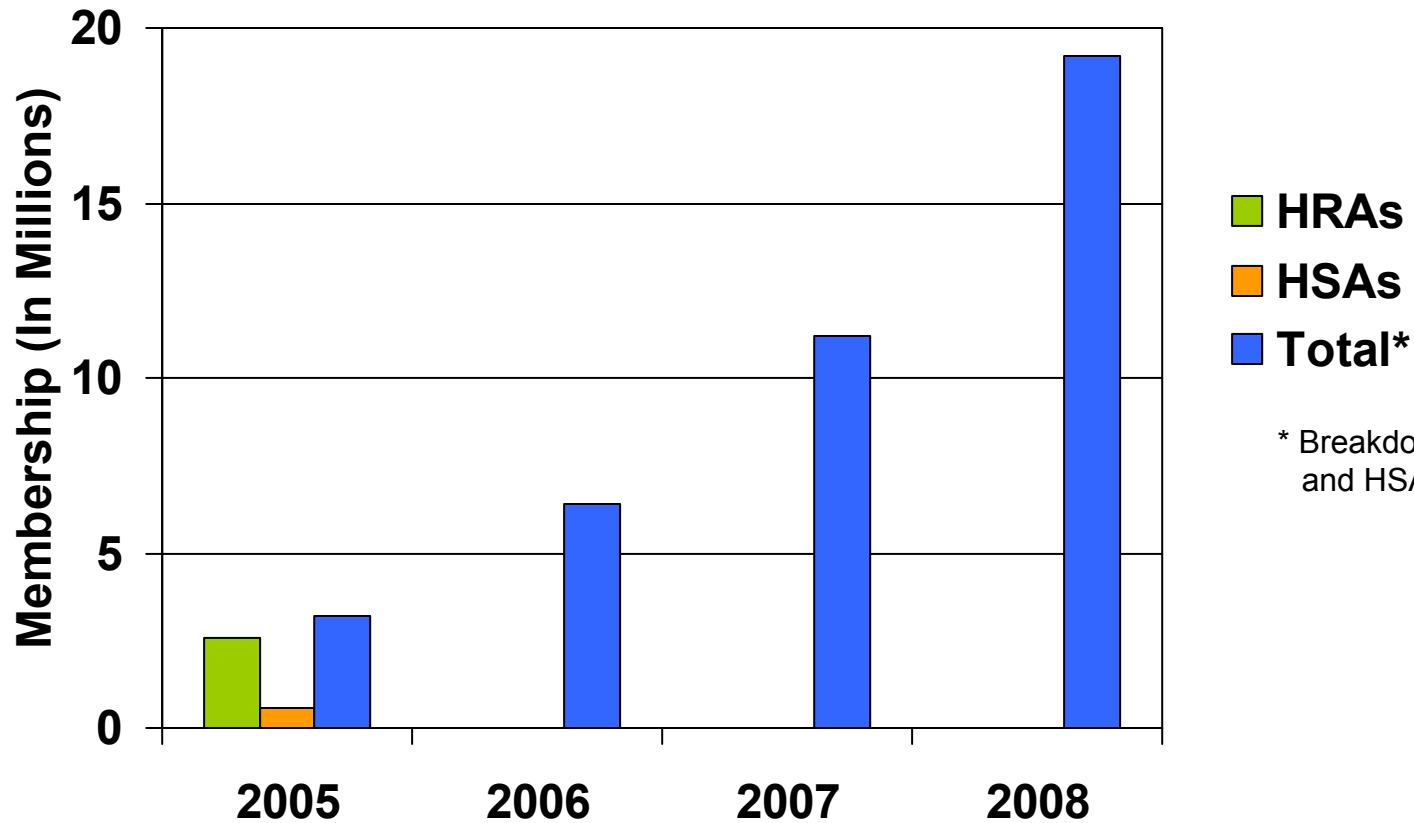
- Approximately 5 million enrolled in a consumer driven programs<sup>1</sup>
  - Estimated to be up to 90 million by 2007<sup>1</sup>
- 12% of jumbo employers (4% of large) offer CDH now; 14% will in 2005 and 26% by 2006<sup>2</sup>
- Employees' cost share will increase by 15% in 2005<sup>3</sup>
- Market consolidation and large carriers employees ALL on plan
- CDHP premium growth from \$7B today
  - Estimated to be \$192B in 2008

<sup>1</sup> Ed Hanway, Chairman & CEO of Cigna, December 2, 2004 Press Release

<sup>2</sup> Mercer 2004 Health Plan Cost Survey Press Release November 2004

<sup>3</sup> Towers Perrin – Monitor November/December 2004

# CDHC Market Forecast: Growth in Membership



\* Breakdown of total between HRAs and HSAs is only available for 2005.

Source: Forrester Research, 2003  
Inside Consumer-Directed Care, December 17, 2004

# Employers: Consumerism & CDHP's \*



	<u>All</u>	<u>Large (500+)</u>	<u>Jumbo (20K+)</u>
Part of strategy	30%	49%	67%
Website on cost/quality	32%	49%	
“High performance networks”	19%	19%	19%
CDHP in 2004 offered	1%	7%	12%
CDHP in 2005 offered	12%	14%	
CDHP in 2006 likely	16%	26%	
Used HRA in 2004 (if CDHP offered)		80%	
Will convert to or add HAS 2005		35%	

Mercer 2004 National Employer Survey

## Employer CDHP Feedback To Date: “Most Important Objectives Met”\*



- Did your consumer-driven plan promote health care consumerism and lower cost?
  - 53% Agree
  - 41% Too soon or neutral
  - 5% Disagree

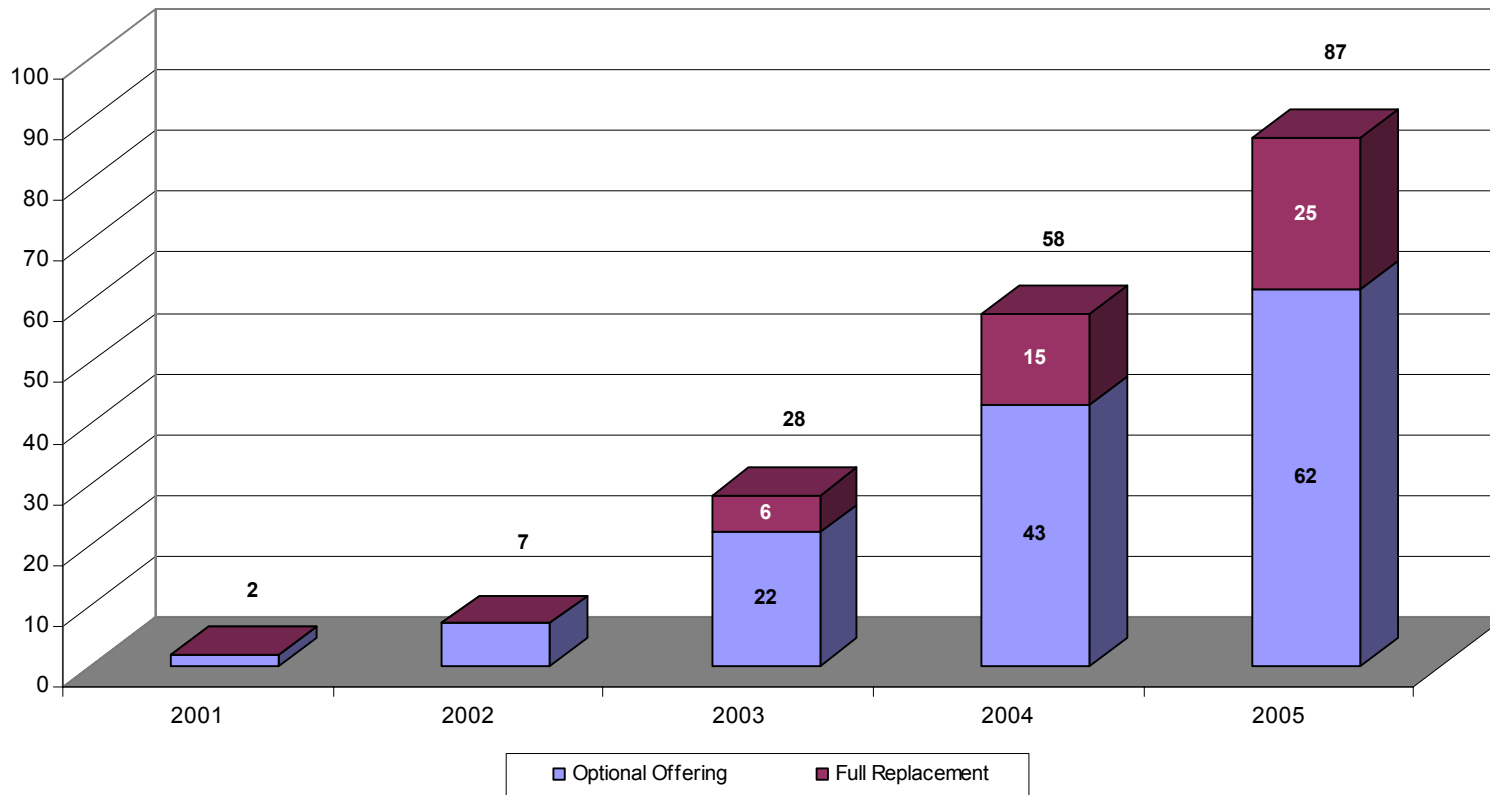
\*Mercer 2004 National Employer Survey



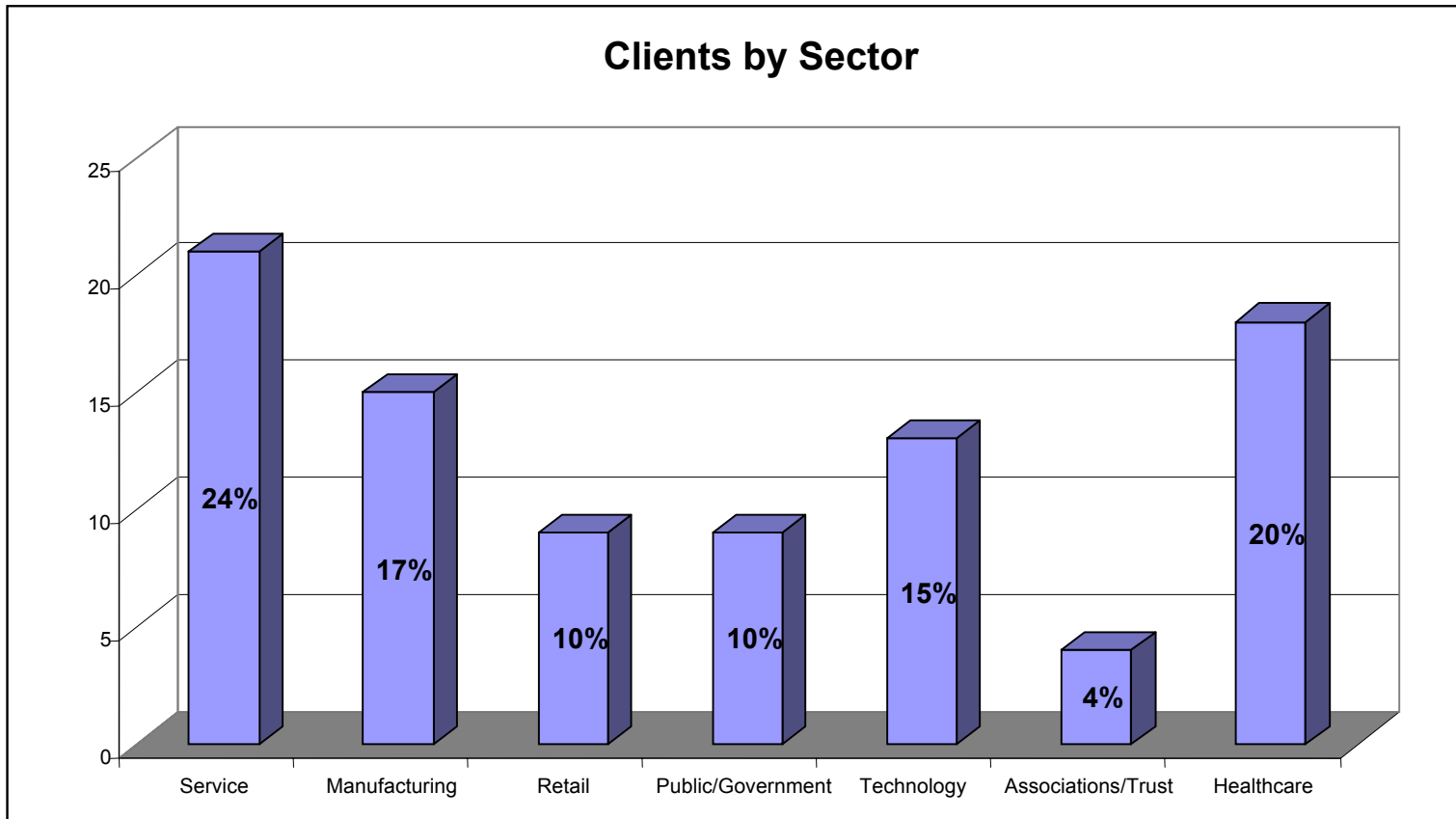
# Lumenos Client Growth



## Lumenos Client Growth 2001-2005



# Lumenos Clients by Industry



# “The Third Party’s Over”\*



- Even modest Health Savings Account adoption will revolutionize industry
- Creates new threats and opportunities for industry incumbents and new entrants
  - Underwriting
  - Payment transaction specialists
  - “Infomediaries”
  - Asset managers

\*Mango and Riefberg (McKinsey and Co), Wall St Journal, 18 Jan 05, p B2



“Medicare’s goal is consumer-directed, patient-centric, prevention-oriented health care.

We need to encourage, support and reward continuous high quality care in which the consumer is actively involved because data shows that it increases compliance with evidence-based medicine, improves outcomes and reduces costs”

Remarks to National Consumer Directed Health Care Congress, May 2005

# Medicare Modernization Accelerates Consumerism



- Hospital quality and “service” metrics
  - [www.hospitalcompare.hhs.gov](http://www.hospitalcompare.hhs.gov)
- Hospital risk-adjusted payments to be phased in
- Standardized ambulatory metrics soon
- Incentives for hospital IT enhancements
- P4P and “Disease Management” demos
- Health Savings Accounts: “transformational”
- Medicaid consumer-driven discussions

# Principles Behind Lumenos/CDHP

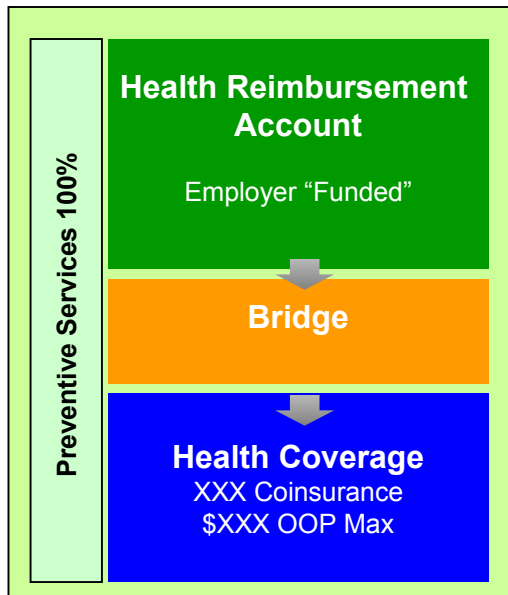


- Focus is on the consumer
- Properly aligned financial incentives
- Price Transparency
- Enable consumers to better manage their health
- Educational and health decision tools
- Personal assistance in managing health issues
- Renewed emphasis on preventive care
- Significant investment in consumer centric technology

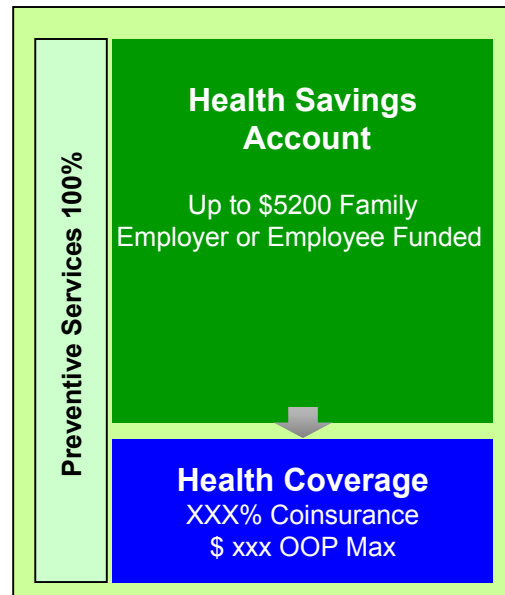
# Consumer-Driven “Account-Based” Products



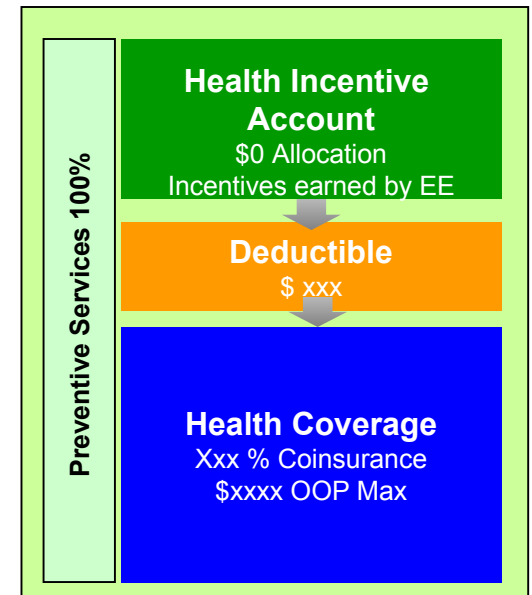
## HRA Product



## HSA Product



## HIA Product



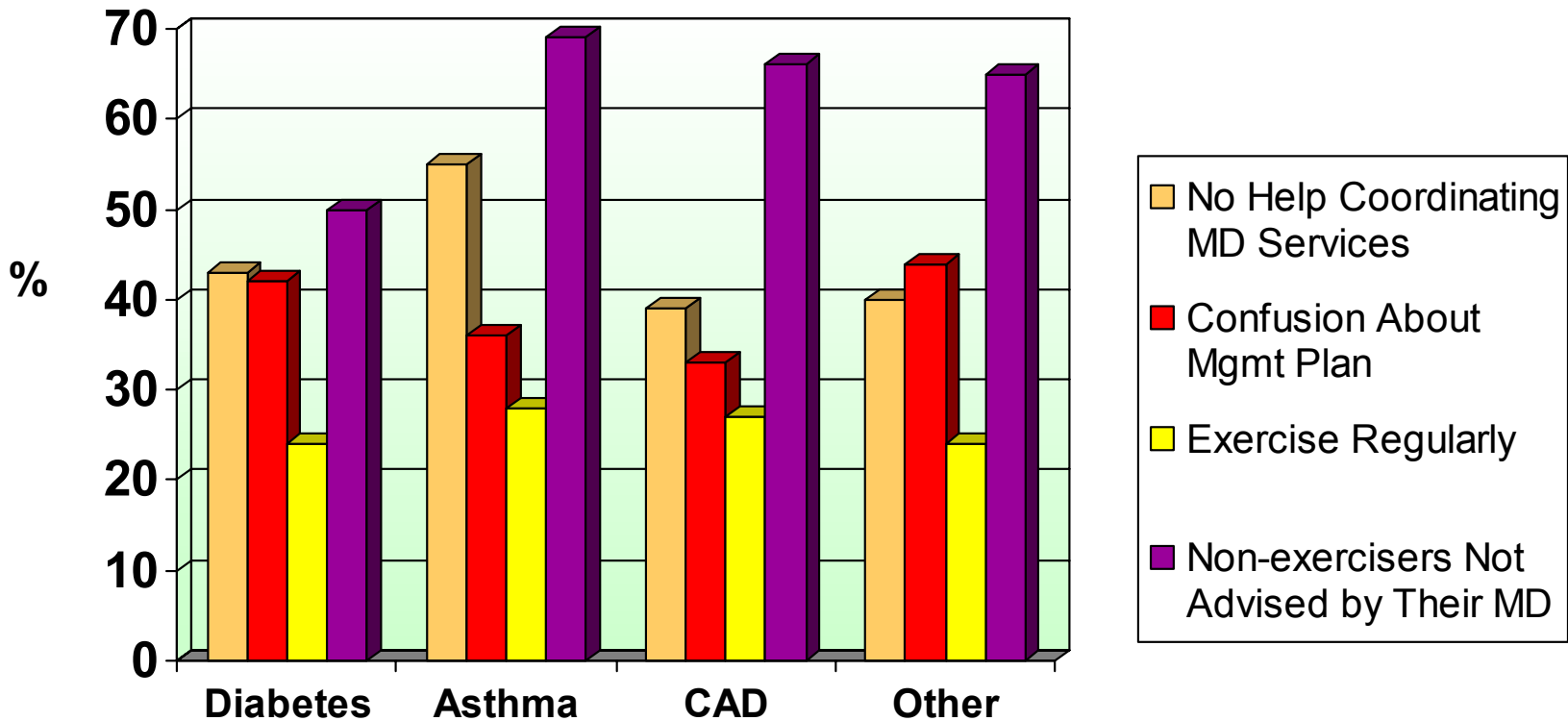
# SA Compared to HRA



Feature	HRA	HSA
Who Contributes	Employer only	Employer and/or Employee
Account Funded	No	Yes
Funds Availability	Immediate	When deposited in the account
Ownership balances at termination?	Return to employer	Remains with consumer
Contributed maximums	Dictated by plan design	Lesser of than the annual deductible or a maximum of \$2,650 single, \$5,250 family per year
Additional Contributions Allowance	N/A	Age 55 or older \$600 annually
Roll-over	Yes - employer determined	Yes
Allowable medical expenses	213 expenses – employer discretion	213 expenses – employee discretion
Account ownership	Employer	Employee
Tax Treatment - Employee	No employee tax deduction	Contributions may be pre-tax or tax deductible
Tax Treatment - Employer	Reimbursements tax deductible	Contributions tax deductible
Cash-out options (non-medical)	None	Taxable pre-65 with a 10% penalty
Portability	Yes – employer discretion	Yes – completely
Claims Adjudication	Required	Not for HSA – will need it for high deductible plan
Financial partner requirement	No	Bank or Trust
Investment options	No	Yes
Combined with FSA/HRA	Yes	Not for medical – may use FSA for Dental or Vision



# Why a Personal Health Coach? Educate, Coordinate, Motivate



RWJF/FACCT Portrait of Chronically Ill in America Survey, 2001

# Why A Personal Health Coach? Partner, Engage and Activate



- Does your doctor:
  - Offer choices in medical care?
  - Discuss pros and cons of each choice?
  - Ask you your choice or preference?
  - Take your preferences into account when making decisions?

**No = 50%**

## And more . . . “Does Your Doctor . . . ?”\*



	Always	Usually	Sometimes Never
Listen carefully to you?	58%	25%	15%
Explain things so you understand?	58%	25%	15%
Give clear instructions?	60%	24%	13%
Provide choices and ask your opinion?	29%	23%	44%

Schoen et al, Adults Primary Care 5 Country Survey, Health Affairs 23: sup 2, 2004; W4 487-503

# Employee Satisfaction and Behavior Change



## Lumenos 2004 Customer Satisfaction Survey

- Mail survey administered to all 2003 members
- There was a 24% response rate to the survey

## Key Findings

- 95% understood how the CDHP plan works
- 93% of customers are satisfied (compared to 87% for competitive health plans)
- 92% are likely to renew (compared to 78% for competitive health plans)
- 93% cite the ability to roll over money
- Customers report health- and cost-related behavior changes since joining Lumenos
  - 44% report increased knowledge in managing their health care
  - 27% report that they are more actively involved in health-related behaviors
    - 77% report improved diet/nutrition
    - 71% report increased exercise



# Incentivized and Integrated Health Management

# Imagine If . . .



- Individuals saw the money spent from their paychecks and in their taxes for healthcare . . . As their own (it is)
- Individuals knew that 50% or more of health outcomes and costs came from personal health behaviors
- Individuals were incentivized to know and improve those behaviors (they never have been)
- Individuals knew that 35% of all care was wasteful . . . And came ultimately from their pocket (it is and does)
- They had health plans that incentivized prevention-oriented, evidence-based and appropriate care
- Willing patients and willing physicians had information on price and quality to better inform decision-making?

# Primary Drivers of Health Care Costs



- 50-70% of all health care costs and premature death, illness and disability are related to behaviors
- Health and health care are only remotely related
  - 35% of all health care costs are wasteful or inefficient
  - Only 50% of high dollar claimants are predictable in any given year from previous
- Effective health plan MUST simultaneously deploy
  - broad, population approach (don't get near the cliff!)
  - targeted, high risk/cost approach (near or over cliff!)
  - decrease costs and improve health
- Quality costs less, not more

# The 50% Story . . . Again\*

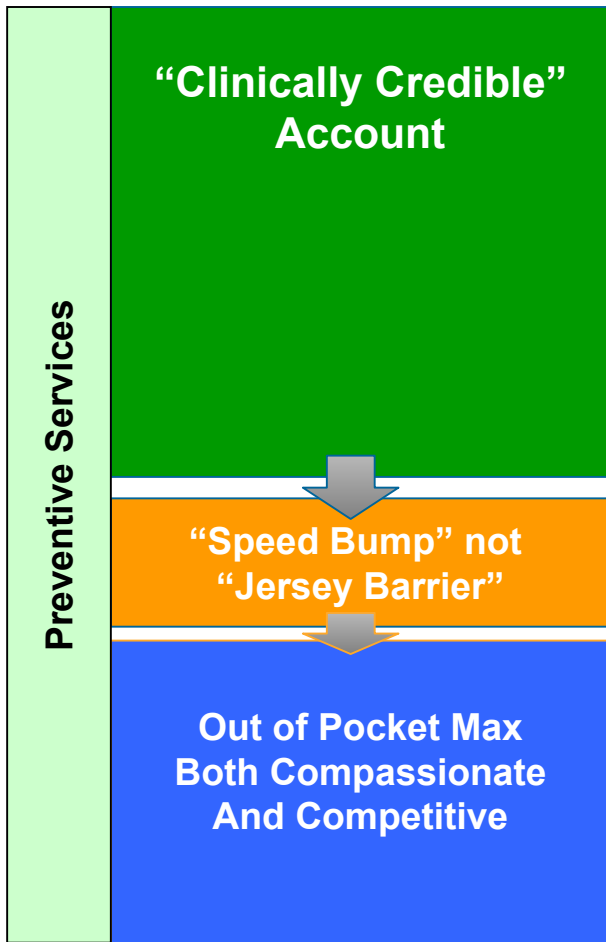


<b>Condition</b>	<b>% Receiving Recommended Care</b>
Breast cancer	76%
Heart attack & coronary artery disease	68%
Immunizations	66%
High blood pressure	65%
Osteoarthritis	57%
Asthma	53%
Diabetes	45%
Urinary tract infection	41%
Sexually transmitted diseases	37%
Gastrointestinal disorders	29%
Counseling and behavior change	18%

\*McGlynn et al, NEJM 348:2635-2645 2003



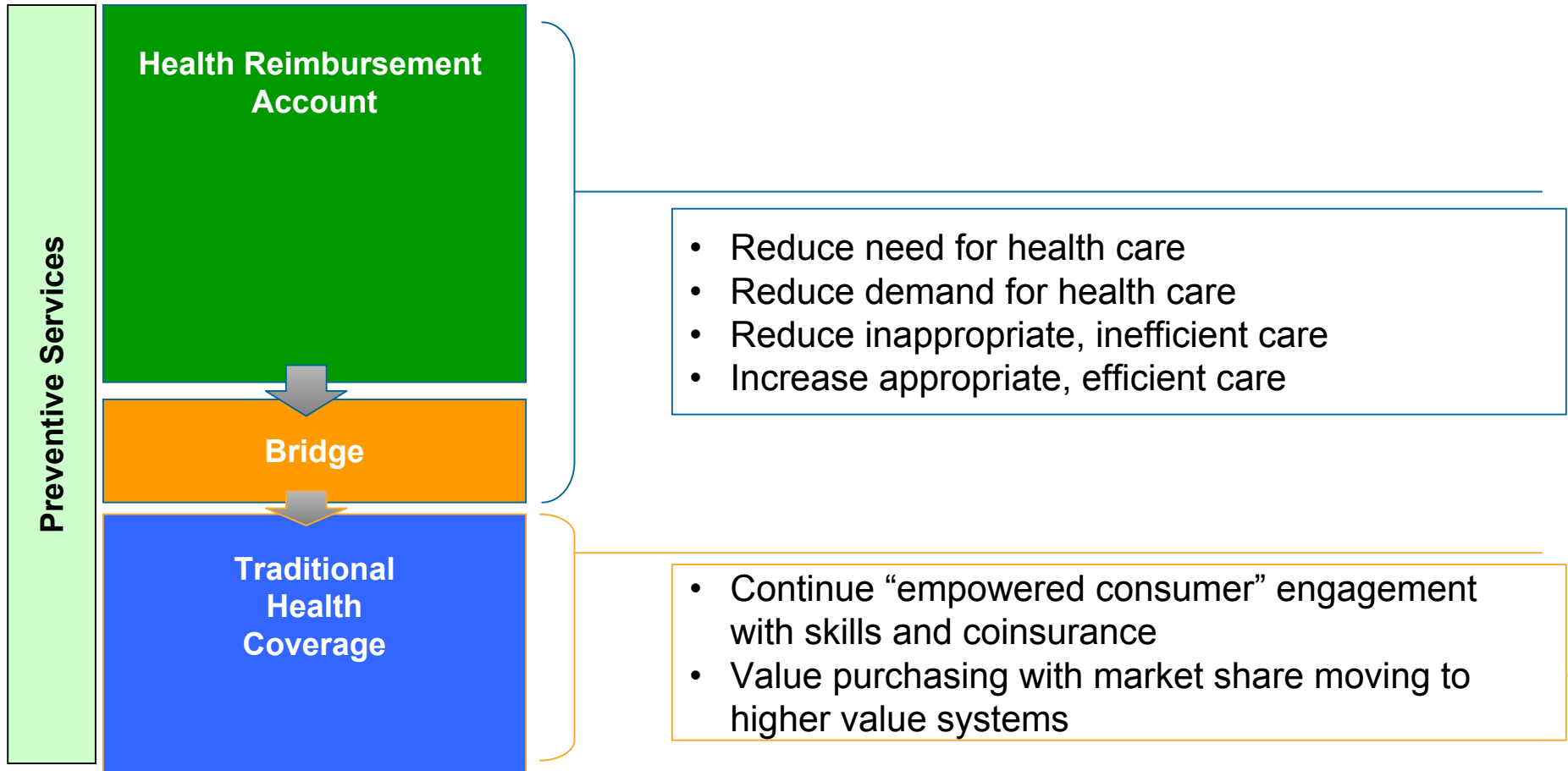
# Benefit Design Imperatives To Attract High Utilizers and Chronic Disease



- Preventive services 100% covered
- “Clinically credible” – for most of the time, does this amount meet my and my families needs?
- Bridge is “speed bump” not real or perceived “barrier” to traditional health insurance

- Highest users solve for Max OOP
- Must be “compassionate” not to bankrupt individual and “competitive” relative to other options and/or previous years experience

# LOM and Health Care Imperatives



# Preventive Services



- **Financial**
  - Incentivized either “carved in” or “carved out”
- **Clinical and evidence-based effectiveness criteria**
  - Excellent (USPSTF, ACIP/AAP etc)
- **Coverage policy issues**
  - Widespread acceptance post managed care
  - Enrollee marketing and communication “must do”
  - New FDA-approved screening technologies awaiting review
  - Commercialized “total everything” screening, more costly and less pressure currently: negative or absent evidence
- **Likely utilization impact**
  - Drive optimal receipt with other strategies

# RA/Bridge and Health Savings Account



- **Financial**
  - “My money” with accumulation potential increases threshold before “traditional health coverage” and attendant behaviors
  - Market vice insurance forces may predominate as HRA and Bridge amounts increase to reflect rising costs and utilization
  - Health Savings Account likely more “powerful” than HRA
- **Clinical and evidence-based effectiveness criteria**
  - Many underutilized effective care practices (IOM, RAND) exist
  - Overutilized, ineffective but never evaluated practices likely persist
- **Coverage policy issues:** geographic variation around alternative care
- **Likely utilization impact**
  - Fewer visits, interventions and Rx drugs
  - More convenient but costly if not of greater “value” may not be selected

# Traditional Health Coverage



- **Financial**
  - Hospital charges/costs transparency initially less
  - High rollover amounts or “richer” HRA’s likely will increase cost awareness in higher cost procedures and care
- **Clinical and evidence-based effectiveness criteria**
  - Must rely on tech assessment groups
- **Coverage policy issues**
  - Hi cost, marginally effective practices still problematic
  - Gastric bypass, genetic drugs, stents/ICD’s: “societal” challenges
- **Likely utilization Impact**
  - “Hey, that \$400 was supposed to be paid by the clinical trial”
  - “Engaged consumer” skills may improve use because of concern about medical effectiveness, not cost initially

# Medical Practice Today: “Hamster Health Care”

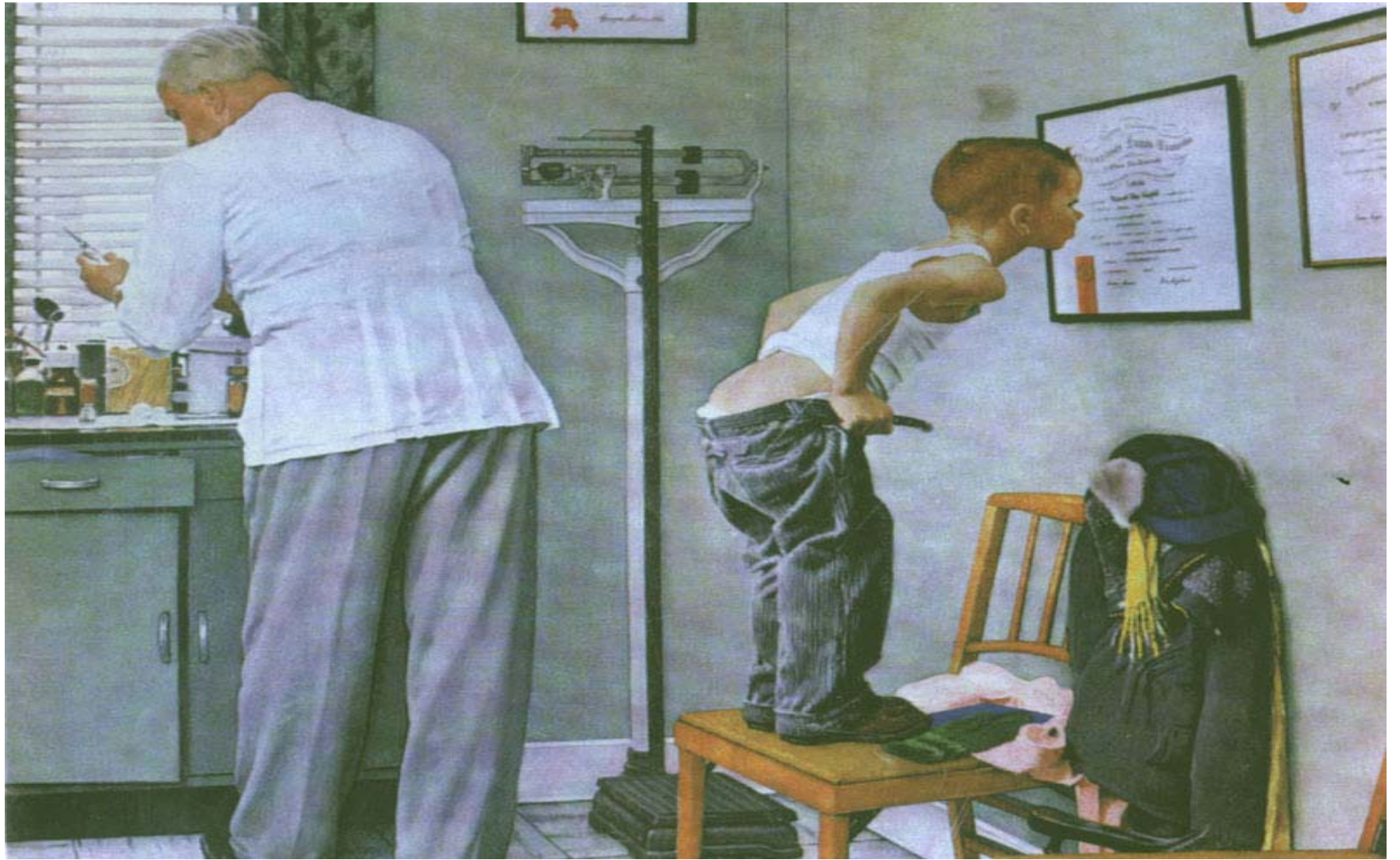


## Symptoms

- Inadequate time with patients
- Administrative hassles
- Patients who know and demand more
- Greater accountability
- Decreasing reimbursements
- Rising overhead costs

## Signs

- Waiting times for appointments
- ER for non-urgent visits
- Managed care backlash
- Inadequate management of chronic illness
- MD burnout and retirement
- “System” collapse?



# Patient-Physician Cost (non) Communication\*



- 63% of patients want to discuss out-of-pocket costs with their doctor
  - Only 15% of patients actually have
- 79% of physicians believe their patients want to discuss these costs
  - Only 35% of doctors actually have
- Smaller, community-based practices where physicians more aware of financial burden more likely to discuss

\*Alexander et al, JAMA 2003;290:953-958



# Early Physician and Health Care System Response



- Supported by AMA and leading medical associations
- Clinical
  - Provides information, tools and personal support for patients to understand and follow care management
  - Supports more efficient physician-patient and system interactions
    - at no cost to medical practice
  - Prevents “Google Syndrome”!
- Administrative
  - Decreases administrative hassles at point of care
- Baylor MD leadership: “Best news in 25 years of practice”
- Texas Hospital Association endorsed Lumenos consumer-driven plan

# What the “ROI” Evidence Shows . . . And What Lumenos Does

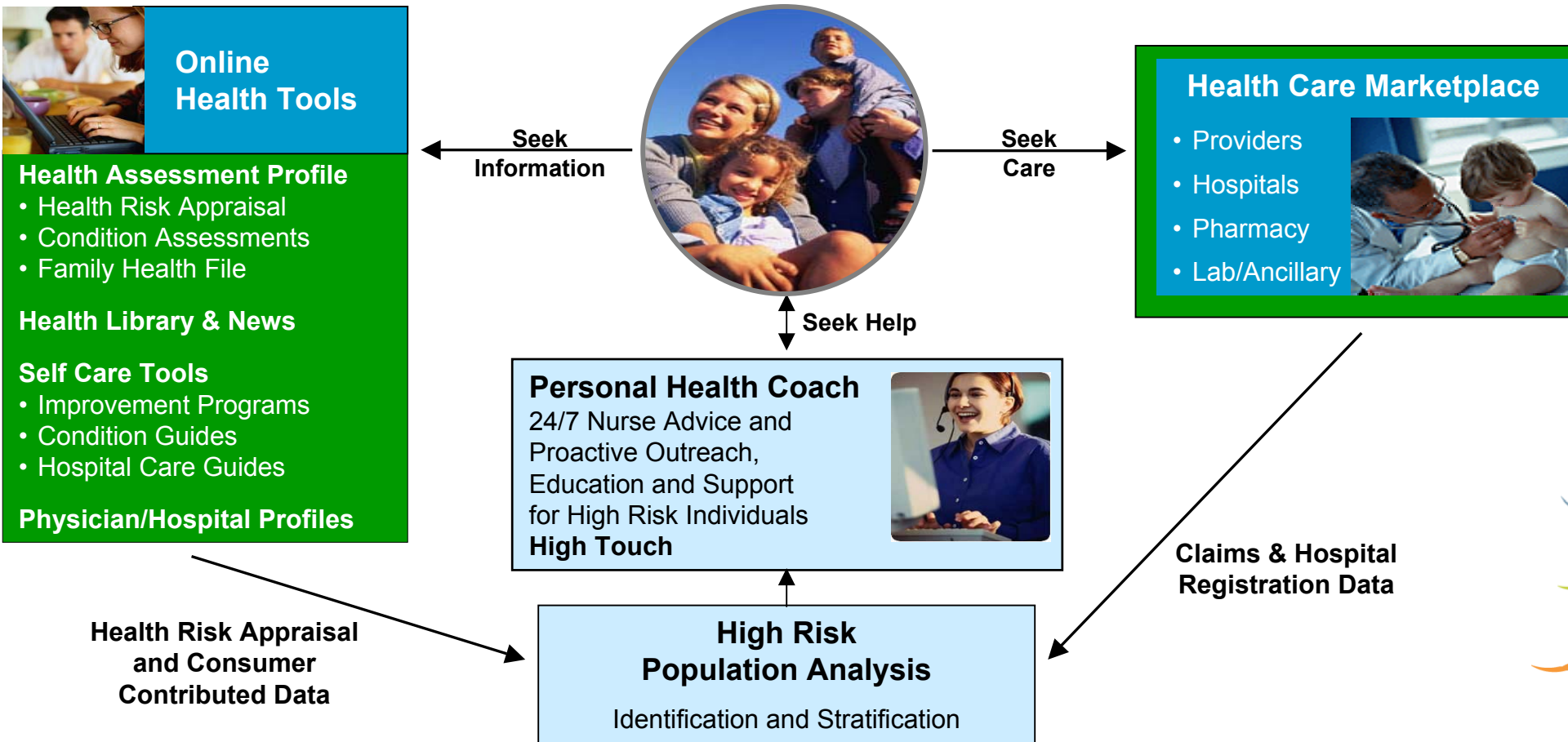


- Risk factor decrease in pre- or post-disease management leads to reduction in medical & disability claim expenses
  - Within 1-3 years post reduction
- “DM” proven for diabetes, asthma, CAD, CHF and +/- depression, low back pain, and early prenatal care
- Incentives “work” and “matter” – AHRQ 2004 study
- Lumenos creates incentives for consumers to identify and reduce risk factors and improve chronic disease outcomes
- Ultimate “ROI” is total cost reduction/mitigation from deployment of care management strategy and integration

# Consumer-Centric Health Improvement Model



## Lumenos Consumer



# Integrated Health Improvement Incentives



- **Identification: Health Risk Appraisal**
  - \$50-\$100 HRA allocation for online completion
- **Engagement: Personal Health Coach Enrollment**
  - Additional \$50-100 HRA allocation for chronic disease or high risk
  - Agrees to participate in Personal Health Coach Program after initial assessment
  - Commits to engage with Personal Health Coach through regularly scheduled meetings to identify goals, become educated and skilled in working effectively with their physician to manage their disease.
- **Graduation: Competencies Mastery with Personal Health Coach**
  - Additional \$100-200 HRA allocation for mastering HealthModels
  - Consumer achieves predetermined goals and documentation of competencies for disease(s) with knowledge, skills, functional provider-patient relationship and clinical outcomes

# Incentives Work and Matter: Assessment and PHC Enrollment\*

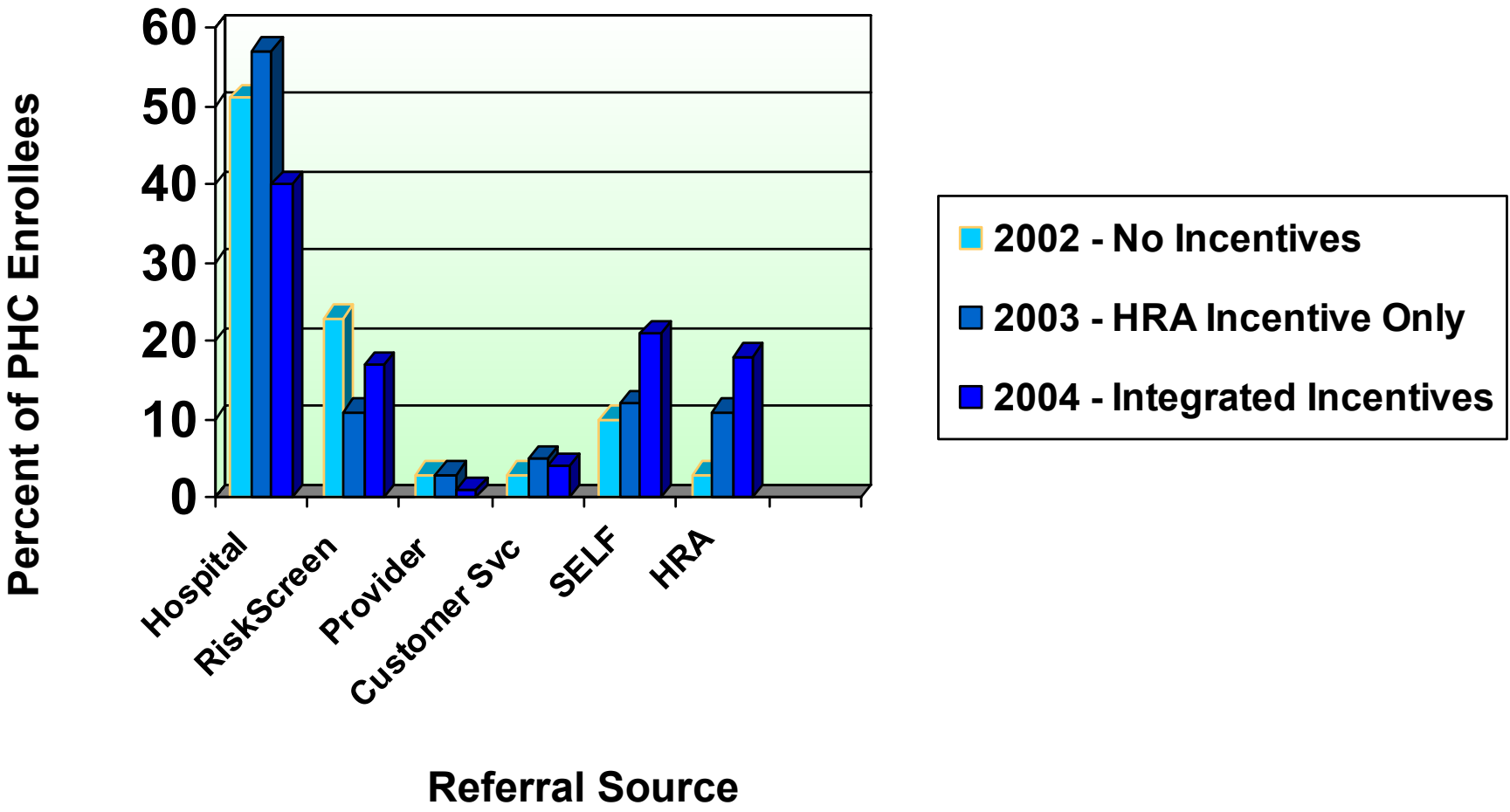


Incentive Status	Participation Average (Range)
Health Risk Assessment	
Incentive (\$25-250)	36.3% (14.8 – <b>80%***</b> )
No Incentive	4.3% (3.3 – 10%)
Increased Risk Assessment completion	8-9X (up to 20X)
Personal Health Coach Enrollment**	
Incentive (\$50-200)	2.3% (0.9 – <b>7.9%***</b> )
No Incentive	1.3% (0 - 2.8%)
Increased Health Coach Enrollment	2X (up to 14 X)

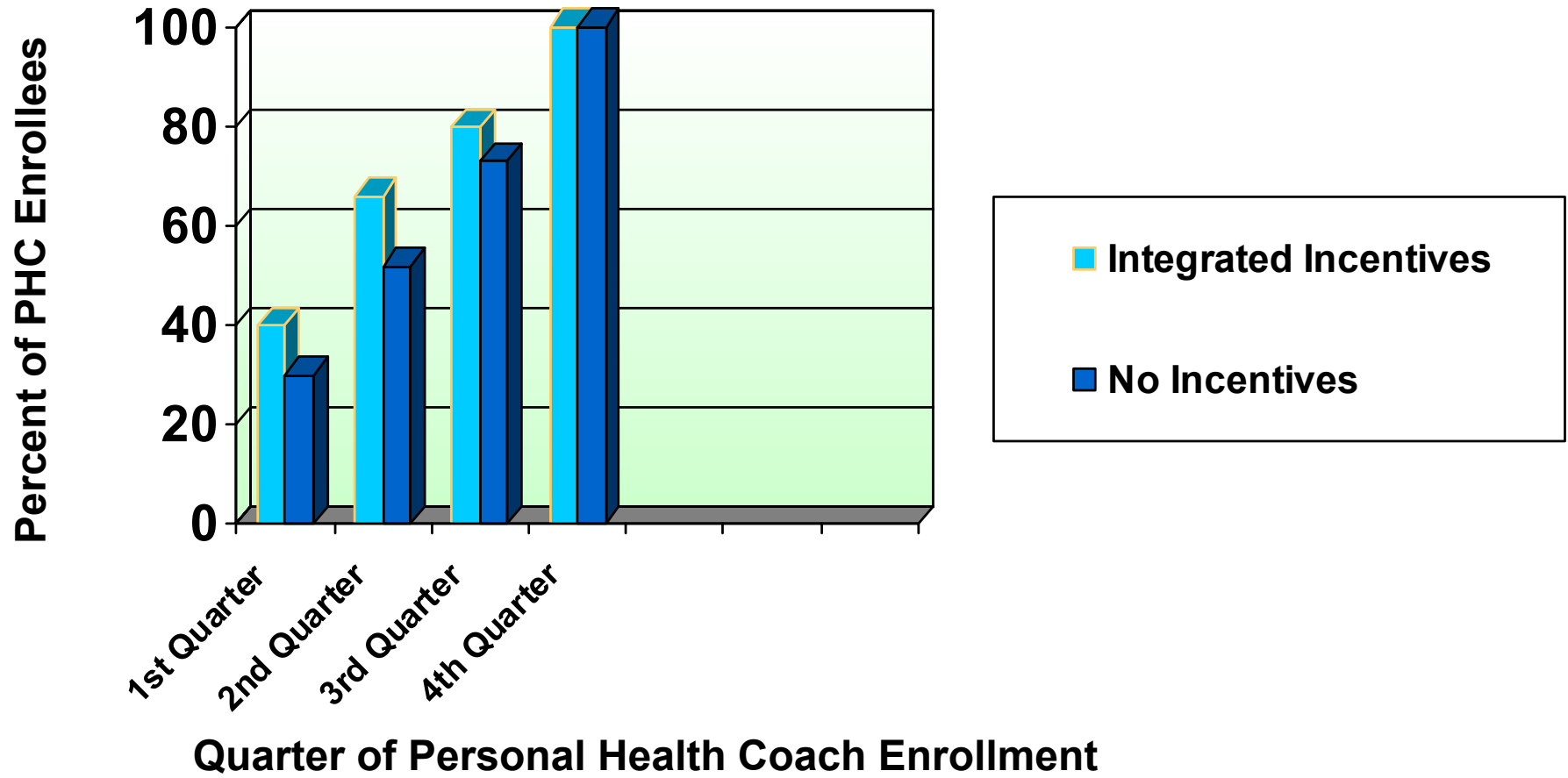
2004 Clients

\*\*\*Full replacement 2004 client (\$250/\$200/\$200)

# “Active” PHC Enrollment Routes Growing With Integrated Incentives



# Earlier Enrollment In Personal Health Coach Program With Incentives



# 10M 15 Priority Conditions



- Cancer
- Diabetes
- High Cholesterol
- Hypertension
- Ischemic Heart Disease
- Stroke
- Arthritis
- Asthma
- Emphysema
- HIV/AIDS
- Gall bladder disease
- Stomach ulcers
- Back problems
- Alzheimer's disease & dementia
- Depression & anxiety disorders



# We Want to Attract the Sicker, Highest Utilizers



- “Integrated” and “incentivized”
  - Identification, intervention, high tech and high touch
- “Competency-defined,”
  - Evidence-based guidelines translated into consumer competencies to know, develop and “own” the skills to master their unique condition(s) in concert with their physician and specialized RN Personal Health Coach
- “Software-supported,”
  - HealthModel software tailored to the patient’s condition, clinical needs and physician relationship
- “Behavior change curriculum”
  - You need a coach/teacher using a curriculum, motivation and support to improve care management and behaviors

# Personal Health Coach

## A 4 - 5 Month Partnership



- Assessment with comprehensive interview
  - Medical history, medications, review of systems, lifestyle behaviors, depression screen
  - Functional assessment (SF-12) pre-, post-
- Basic education about disease/condition
- Comparison of treatment plan with current guidelines
- Clarification of patient's belief and value system
- Assessment of self-management motivation and capability
- Specification of principle care physician and next appointment
- Creation, support and adoption of self-management plan

# Diabetes Measures and Recommended Data Sources



- HbA1c management
  - Record or admin
- Lipid management
  - Record or admin
- Urine protein testing
  - Record or admin
- Eye examination
  - Record or admin
- Foot examination
  - Record or pt survey
- Influenza immunization
  - Record or pt survey
- BP management
  - Record
- Office visits
  - Record or admin

AMA, NCQA, JCAHO Core Measurement Set for Adult Diabetes, April 2001

# Consumer-Oriented Diabetic Competencies: The “Flip Side” of EBM



- “Did you receive a HbA1c and what was it?”
  - Report: Yes/No and within what range
- “Do you know your cholesterol and lipid levels?”
- “Was your urine tested for protein?”
- “Were your eyes examined and dilated with drops by an ophthalmologist?”
- “Did your physician or her staff examine your feet?”
- “Did you receive your flu shot?”
- “Do you know your blood pressure?”
- “How often did you visit your doctor for your diabetes last year?”

# “Pay for Performance” Perspectives



- WHO has to perform?
  - Lumenos pays consumers and believes that the market will then reward the best providers with volume and pricing
  - Consumer incentives should reflect provider incentives
- HOW should it be paid?
  - “Cash is King” and prompt rewards reinforce behaviors
- WHAT measures?
  - Consumer “mastery” of disease competency = “graduation”
  - Provider level metrics currently not uniform
  - Lumenos posting NCQA provider level recognitions for heart disease, diabetes and QI procedures

# Pay For Performance Strategic Alignment Possibilities



- Align incentives, strategy and tactics
  - Consumer and provider “P for P” alignment
    - HRA, PHC enrollment and graduation incentives
    - Provider reimbursement and identification based on provider-focused methodologies
      - Many different programs and measures currently hamper widespread adoption
      - Lumenos consumer-focused competencies “matches” ALL and measures what MOST matters in near term

# Pay for Performance and Tiering Rollout

## Feedback on Version 1.0”



- Employees and consumers\*
  - 70% don't believe such programs result in better quality
  - 51% believe it's a good idea to offer “bonus pay” to docs (vs 84% for teachers and 87% for sales clerks”
  - “I wouldn't BE with my doctor, if she was poor quality” (patient who's doc didn't make UHC's “top tier”)\*\*
- Physicians and providers\*\*
  - No prior notice, 40% eliminated from process for “not enough data”, proprietary claims methodology not shared, disrupting trusted specialty referral patterns

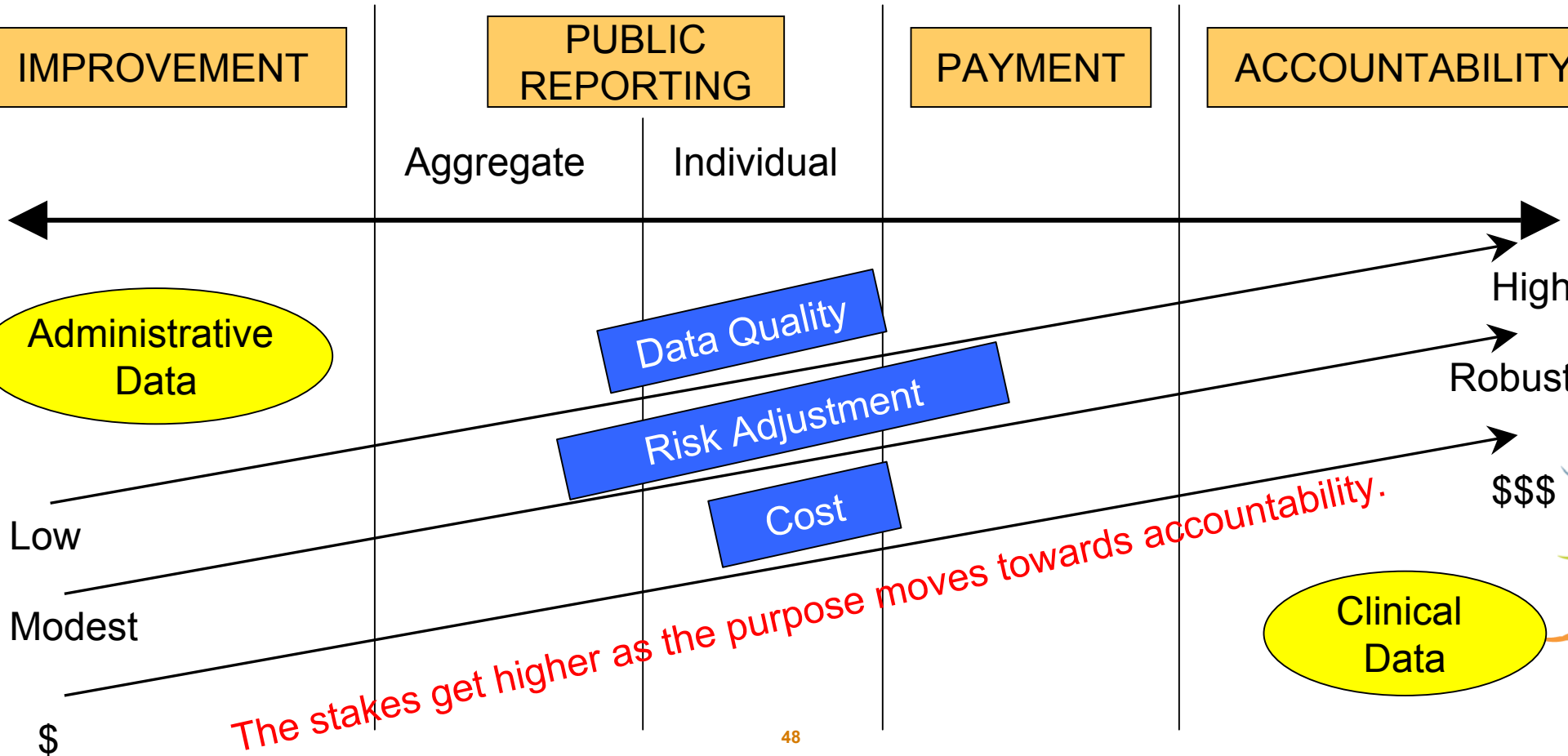
\*Managed Healthcare Executive, December 2004

\*\* “Health insurance program aimed at efficiency brings confusion, outrage”, St Louis Post Dispatch, 2/13/05

# Importance of Considering the Purpose of the Quality Measurement\*

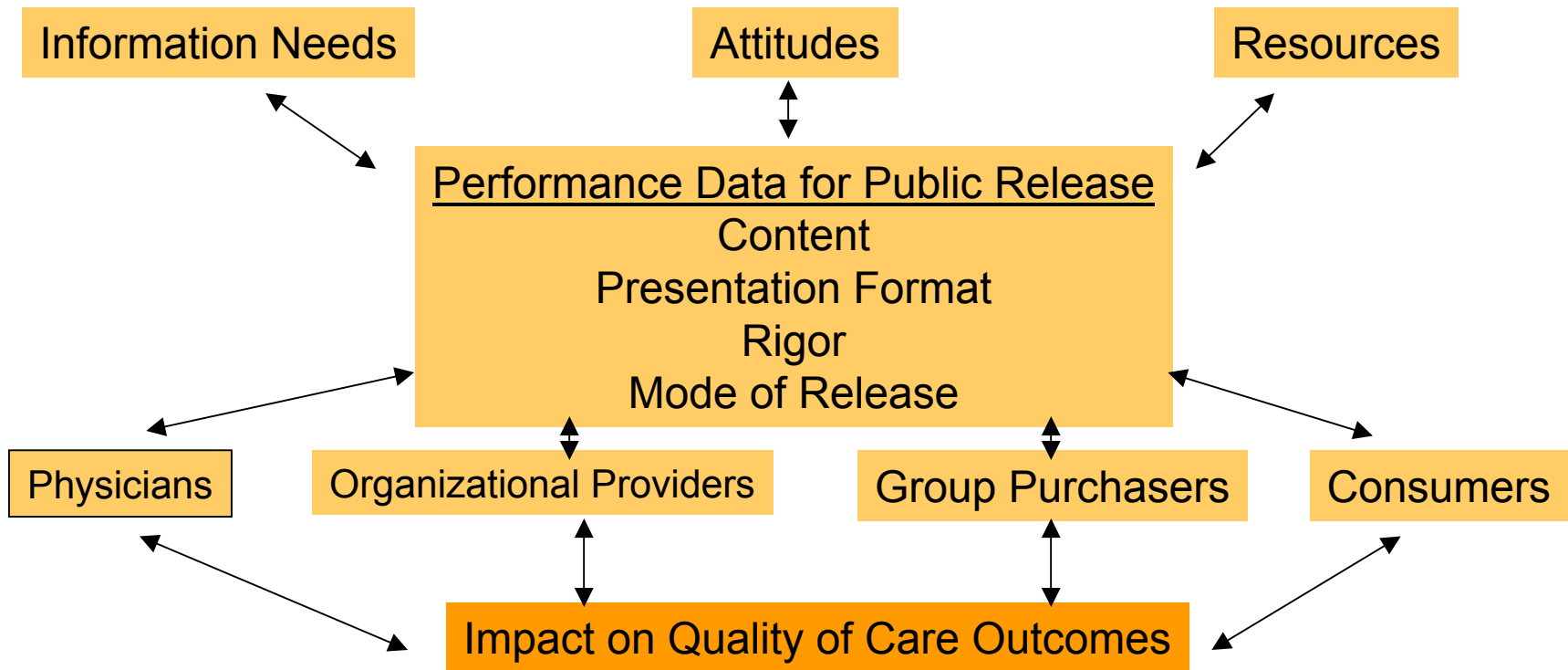


Meyer, G – submitted for publication





# Public Disclosure of Performance Data\*



\*JAMA 2001; 283:1866-74

# Begin With The End In Mind



- Rapid and accurate payment
  - Simplified fee schedule and coding
  - Cash discount
  - “All inclusive fee” pricing?
- Competitive pricing
  - Potential for innovative payment structure
  - Web-based consultations and reimbursement
- Transparency
  - Cost
  - Quality
    - NCQA physician-level designation (CQI, diabetes, cardiac)

# DM Principles for Payment Methods

## o Improve Quality



- Fair payment for good clinical management
- Providers share in benefits of improved quality
- Promote consumers and purchasers to “buy quality”
- Align financial incentives with best practices
- Reduce fragmentation of care
- Some possibilities
  - “Blended” payment methods
  - Multiyear contracts and bonus incentives
  - Risk adjustment
  - Electronic interactions payment
  - Bundled payments

# Today's Challenges Unchanged From 20 Years Ago



- Adverse selection
  - Yes it happened, particularly with HMO's
  - Can be mitigated with benefit design
  - Full replacement: a non-issue and its happening
- Care coordination for chronic disease
- Optimal payment mechanisms
- Performance measurement systems
- Provider and “system” response
- “Individuals can't do it”
- Insurance function vs “routine care”

# Health Care PROVIDER Take Homes: Time-limited Opportunity?



- Leaders in health care delivery should lead the consumer-driven movement
  - Shape your market and use platform to innovate
    - “Product line” assessment of competencies and best value critical to growth
    - Value-added innovations for improved outcomes and service should START with providers who know challenges
  - Implement consumer-driven for OWN employees as start for bottom line savings, in-house feedback and strategic input
- Embrace data transparency, cost-effective innovations and value-added business practices
  - Consumers will ask why not . . . And vote with their feet and dollars



Thank You!

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